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Clinical Lectures.

FRACTURE OF THE SKULL; MOTOR LESIONS—CELLULITIS—STRICTURE OF THE RECTUM; COLOTOMY—FRACTURE OF THE GREAT AND SECOND TOES—HÆMORRHOIDS—MALIGNANT TUMOR OF THE LIVER.

BY JOHN B. HAMILTON, M.D., LL.D.,

PROFESSOR OF THE PRINCIPLES OF SURGERY AND CLINICAL SURGERY, RUSH MEDICAL COLLEGE, CHICAGO, ILL.

FRACTURE OF THE SKULL; MOTOR LESIONS.

Gentlemen:—We have here one of the most interesting cases that could be brought before a class. This little fellow, 3 years old, about 18 months ago sustained a fracture of the skull. As I press my finger over the elevated portion of the parietal eminence near the suture on the left side, I can find still a place where the bone failed to unite after the injury. The patient is so frightened at this time that his gait cannot well be seen by walking, but there is a distinct unsteadiness in his gait, showing the weakness of the muscles of the upper portion of the right thigh, and on account of deficient innervation the extensor muscles of the fingers of the right hand fail to act. So then we have a distinct lesion of the motor area on the left side of the brain. My impression is from previous examination of the child when less frightened than at present, that there is an incurvation or projection of the edge of the fractured bone which produces this difficulty. The child is able measurably to contract the finger, but cannot extend it, and the defect in gait is due to irritation of the motor area of the left side of the

cerebral hemisphere. The parent of the child states that for a considerable time after the fracture was received he was unable to walk and that his gait has become more steady as time has progressed. The paralysis of the arm was complete in the beginning; it is now, as you see, steadily improving. The question is, has that improvement reached its limit? We shall keep the child under observation for a period long enough to ascertain whether or not, there is a probability that the extensors will resume their function. If we find under continued observation that the condition is stationary, then operative measures will be instituted. The operation would consist in cutting down over the portion of the bone which was fractured. Examination of the wound and the edges of the bone, as near as I can ascertain, shows that the bones have never completely united after the fracture. There is still a fissure two inches long which has the effect in this case of an extra fontanelle.

In the treatment of this case antiseptic methods are only to be considered. In operations on the dura mater and on the brain itself the main thing to be considered is thorough antisepsis and we may be reasonably sure that improvement, without danger, will follow.

CELLULITIS.

We have here a case of cellulitis of the platysma myoid muscle and its sheath, also of the sterno-cleido-mastoid muscle of the left side. The causes are such as produce inflammation of the intermuscular substance elsewhere, usually referred by the patient to the sudden onset of cold. As we know now it is undoubtedly of infective origin. The boy says he is just recovering from an attack of typhoid fever. Of course, you understand that the typhoid bacillus could in no wise cause this particular inflammation, so it must have been

doubtless some specific pyogenic coccus gaining entrance through the blood-vessels. It is proper to say in this case that the treatment will consist in the application of hot fomentations, which will perhaps disperse the inflammation without operation. The position of the head, held in the position which you see, is simply due to the voluntary contraction of the muscle. The patient places the head in a position which is most easy for him, and consequently the muscles involved are relaxed when placed in that position. If permanently retained contracture results, constituting torticollis.

STRICTURE OF THE RECTUM; COLOTOMY.

We have here a case of a young man, about 35 years of age, who has a very serious affection, it being no less than a stricture of the upper portion of the rectum at about the sigmoid flexure. On attempting to pass a bougie through this stricture it was found very firm and unyielding and high up. It could not be reached with the finger. For some months he has been passing blood at intervals. He has been unable to have a movement from his bowels without a great deal of pain, and usually not without the introduction of the finger and irritation of the mucous lining of the bowel. His condition has become such that he desires some radical relief. We have then to do with a case of obstruction of the bowel due to a stricture—to a new growth probably malignant. It is quite certain that there is no history of syphilis in this case, usually considered in these growths as the most common cause, and the only thing left to consider is the question of carcinomatous stricture. The lumen of the stricture has steadily diminished, and the difficulty of passing feces has increased from the beginning. The amount of blood which has been thrown out either with the passages or violent tenesmus which takes place has also increased. So that when you consider the rapidity of the swelling and the fact that rapid general emaciation has gone on, we may conclude without much doubt that we have to deal with a malignant stricture. Of course, in such a condition a palliative operation is absolutely necessary if we propose to prolong the patient's life. That operation consists in making an artificial anus by an opening in the colon, and in case the stricture should not be malignant we

would by the resting of the stricture have a better chance for examination and perhaps its cure. We will recommend him to have this operation performed in any event. The operation consists in the usual one performed by Mady, which is making an incision through the abdominal parietes, pushing aside the omentum, reaching the colon, pulling it through the wound, putting a glass rod under the colon, through the mesentery, either stitching the bowel to the opening or leaving it alone according to the length of the incision that has been made. If, for instance, the incision is a small one (and the smaller the better), it is not necessary to stitch the bowel into the wound for the reason that its agglutination will speedily take place; it is not likely to collapse because the glass rod will be left in position for two or three days. From the third to the fifth day the bowel, which has been raised over the glass rod, may then be incised either by scissors or by the Paquelin cautery, and the opening is stitched to the wound, if required, after which time we may proceed further and remove the stricture by incision of the coccyx, removing it through the pelvis, or the question may arise whether, if it is found to be malignant and constantly growing, we shall allow the artificial anus to remain during the rest of the patient's life. There is no question about the relief afforded by the operation when successfully performed, and under ordinary precautions there is little risk of adding to the patient's danger.

The line of the incision is easily found by drawing an imaginary line from the anterior superior spine of the ilium to the umbilicus. We bisect that by a line drawn at right angles with this line, having it partly about and below the imaginary line, so that by making an opening in that situation we shall come directly upon the colon.

We have now arrived at the peritoneum, which I will incise. I now pass my finger into the rent that has been made in the peritoneum and search for the colon. Usually where there is very much obstruction the colon can easily be felt, and the hard lumps of fecal matter resting within it. Sometimes, however, it is a matter of more difficulty, requiring lengthening of the incision. That I do not wish to do if I can prevent it. I am now passing in re-

view through the incision certain portions of the intestine as I find parts of the gut entirely empty, indicating that there has probably been a volvulus in addition to the stricture which is present in the sigmoid. I am trying to withdraw the colon as much as possible from below so as to bring it near the sigmoid flexure. The question now to determine is whether the wound is securely closed around the intestine. If not, it is necessary to stitch it; if it is perfectly closed the stitches will be unnecessary. In order to relieve the pressure from being directly over the center we surround it with a gauze compress on the side. If the patient does well, about Wednesday I shall open this with scissors and remove the glass rod. By that time the posterior portion of the intestine will have become securely fastened into the wound.

FRACTURE OF THE GREAT AND SECOND TOES.

This patient yesterday caught his foot in an elevator shaft and sustained a fracture of the great and second toes. We will irrigate the parts, clean off the clotted blood, and examine it. On examination of the great toe I notice that the nail is loose, it simply hangs by the skin. Its removal will enable me to examine the bone a little more carefully. The end of the toe seems to be a mass of pulpified tissue, but I believe it will unite if thoroughly cleaned and treated antiseptically. I shall now after sublimate irrigation suture the anterior flap directly down to the wound, with the expectation that it will unite by primary union.

HÆMORRHOIDS.

This man, complaining of hæmorrhoids, has an external hæmorrhoid and also some condylomata about the anus. We will turn out the inside of the rectum just above the external sphincter with a view to inspecting the membrane. The external pile is sufficiently obvious. I introduce the speculum in the manner which you observe, using my finger as a guide. There seems to be no disease in the interior of the bowel. The external pile is produced usually by direct extravasation of blood. If you adopt the nomenclature of the Royal College of Physicians it comes under the class of extravasation tumors. From a pathological stand-point a tumor is a new

growth, but under the present nomenclature we would call this an extravasation tumor. I simply pass a grooved bistoury through the pile and turn out the clot by direct pressure. I think it would be well while the patient is on the table to remove these condylomata with the scissors. We now pack the verge with a bit of iodoform gauze, and it will give him no further trouble.

MALIGNANT TUMOR OF THE LIVER.

This patient has been sick five months, and comes here for the purpose of diagnosis. We find an enormous swelling in the abdomen. Let us hear the percussion note whether it is tympanitic or whether it is fluid. It is a solid swelling. If you notice, the sound is flat in this situation on the left side; it is resonant where the air or gas is in the intestine. The tumor is movable from side to side. The patient is jaundiced. The color of the faeces is variable, alternately white and lead colored, consequently we must look to the liver as the organ probably deranged by the presence of this tumor. Its situation is directly over the liver and would seem to indicate that we have to deal with a malignant tumor of that organ. We might have a hydatid swelling, for hydatids are very common in the liver, but we would not have density of structure. As I pass my fingers down on to the tumor I find it perfectly hard and firm. If you notice, on turning the patient on the side the tumor subsides toward the portion of the body most dependent; it is therefore partly movable under the abdominal parietes. As I grasp the parietes in my fingers and then pass the end of the fingers over the contents of the abdomen I am able to map out, as it were, with my fingers' ends, the exact location of the tumor. It is attached to the liver and overlies the stomach. I conclude then that we have to deal with a malignant tumor, because of the rapidity of its growth, its situation, and in fact that it is solid and not fluid. An exploratory laparotomy would undoubtedly do the man no particular harm and would clear up the diagnosis in this case; but I question the propriety of advising the operation as I think it would only result in exposure of a sarcoma which could not be removed. However, I would be willing to make an exploratory laparotomy at any time he so wills it.

There is one word as to the diagnosis in these cases as between general ascites and these abdominal swellings. If we have a dropsy of sufficient extent to make this extension of the abdomen we would also have a pitting of the feet and legs on pressure. Moreover we would not have abdominal resonance. For instance, at this point (illustrating) we have it soft and resonant. The resonance simply indicates where the gas is present in the intestine, and its absence indicates where the tumor is solid. An exploratory puncture would, of course, determine the contents of the tumor whether it be solid or fluid. Further than that, an examination of the fluid might be made. Under the circumstances I would advise this patient to have an exploratory laparotomy performed. He seems to be in good health, not yet cachectic, and can stand the operation without difficulty.

ATTENUATION OF THE TUBERCLE BACILLUS.

Gramatschikoff (*Centralbl. f. allgem. Pathologie*, Band ii, No 25) describes a new method by which the tubercle bacillus may be attenuated. Having inoculated 33 fowls with human tubercle bacilli without any positive results, clinical or pathological—at the most only local tuberculosis occurred—he next sought to ascertain what alterations these bacilli undergo and how long their virulence is retained in the organism of the fowl. With this object pure cultivations, enclosed in parchment, animal membranes, and glass tubes closed by permeable membranes were introduced into the peritoneal cavities of fowls. After periods varying in duration, the inoculated material was withdrawn, sown upon glycerine agar, and also placed within the eyes of rabbits. In this way bacilli of diminished virulence were obtained, the degree of diminution being dependent upon the length of stay in the fowl's body. Some were still capable of producing general tuberculosis; the course of the disease, however, was slow in comparison with that observed in control animals, in which tuberculosis had resulted from inoculation with bacilli of the same generation as those attenuated in virulence. These latter, in other instances, produced only local disease, which healed of itself.—*Brit. Med. Jour.*

THE ANTIPHLOGISTIC METHOD AND THE TREATMENT OF ACUTE PLEURISY

By PROFESSOR PETER,

PARIS, FRANCE.

A CLINICAL LECTURE DELIVERED AT THE HÔPITAL DE NECKER.

Gentlemen:—I do not come to combat thoracentesis. It was under Trousseau that I made my first puncture of the thorax, and I am too well acquainted with the beneficial results obtained from such operation to speak ill of it.

What I propose to say about acute pleurisy is, that the disease remains the same, but that it is the treatment of it which has suffered modifications. To show this I will call your attention to the medication of the past and that of the present.

In regard to the first, I will refer to books very little read nowadays, that is, to the treatise on auscultation of Laennec, 1819, the *Clinical Medicine* of Andral, 1822, and that of Bouillaud, 1837.

For the present I will only call attention to the following points. Laennec says: "In acute pleurisy, when the subject is vigorous and plethoric, the best practitioners of all times and of all countries, have recommended bleeding from the arm, unless the individual be a woman in whom the menstrual period is about to occur. In this instance, bleeding from the feet is preferred. But if the pain and the fever do not subside after one of these bleedings, it will be best in pleurisy, as in all inflammations of the serous membranes, to resort to blood-letting, and, generally, this local bleeding must be repeated until the pain and the fever cease, and also if these symptoms should return. In my opinion, wet-cupping is preferable to bleeding by leeches."

Here you must allow me a slight digression that I may try to make you understand my opinion about the matter, and the absolute usefulness of an energetic interference so timely in the first stages of an acute pleurisy.

By acute pleurisy I understand that phenomenon which occurs in an adult, robust and healthy individual, through the accidental cooling off of a surface temperature which has been produced by a prolonged and active muscular exercise. In

such an acute pleurisy three stages are observed: a hyperæmic stage, a purely congestive one, and as a consequence of this, an affection of the intercostal, and sometimes of the phrenic nerves, constituting, when intense, what is commonly termed a "stitching" pain in the side. Again, and preceding this pain, there are fever characterized by chills, and a condition of general malaise. After a few hours the period of exudation appears, soon followed by the formation upon the pleura of a fibrinous exudate. Then shortly afterwards, there comes on, with a greater or lesser rapidity, the secretory period, with the production of a serous effusion. In the meantime the original pain subsides gradually until it finally ceases, as if the liquid effusion, out of regard, as it were, for the inflamed pleura and the affected nerves, acted as a calming agent. The same results are observed through watering of the eyes in cases of acute ophthalmia.

I shall not dwell long upon the phenomenon of the pain in the side; suffice it for us to know that it is the clamor, the cry of an irritated nerve, situated in the neighborhood of an inflamed pleura; that it is the denouncing manifestation which, after the few hours of a pre-existing fever, comes to point out to us the localization of the malady, and to put us on our guard.

Before the appearance of the fibrinous exudation and, *a fortiori*, that of the serous effusion, the physician has sufficient time to interfere in the production of these two phenomena, and this interference must be proportionate to the intensity of the fever and the acuteness of the thoracic pain.

These are, therefore, the two chief indications: To combat the fever and to prevent the fluxion. This is what was admirably understood by our forefathers when they practised a general blood-letting to combat the pleuritic fever, and when, on the other hand, they applied wet-cupping and leeches, and, one or two days later, a large blister to act against the local inflammation.

Under analogous conditions, if this treatment is put into practice at the beginning of the pleurisy, we obtain a double result: 1. There will be no serous effusion, or at least a very small amount. 2. The duration of the disease is notably shortened. In this manner the general disorder has been averted and the local trouble stayed.

Such has been noticed in the first thirteen clinical observations of Andral. This author cites ten cases of acute pleurisy that terminated in recovery; three got well without effusion, and in seven the effusion was slight, but totally disappeared under the antiphlogistic treatment. These ten cases were observed in the period of ten months.

Bouillaud has reported twenty-one observations of acute pleurisy, of which only the first case terminated in death. The antiphlogistic treatment consisted in repeated bleeding, wet-cupping and the application of large blisters. I believe that this treatment is too energetic, and that it may be employed in a more moderate manner, with the same amount of success. I believe, on the other hand, that it was the excess of such measures that, in the hands of Bouillaud, produced a reaction in an opposite direction, and that a treatment which is both rational and efficacious was thus abandoned. But certainly worthy of notice, especially in the observations of Bouillaud, is the tolerance of the system towards these large blood-lettings; the rapidity with which the pain ceased, followed by the abatement of the local trouble; the re-absorption of the effusion and the recovery of the patient. In fact it is remarkable that in thirty-one cases of both Andral and Bouillaud, there was only one death, and this in the case of an individual whose system had been previously run down.

You will not forget the fact that only 1 death occurred in 32 cases of acute pleurisy observed in the course of a year, more or less. I will return to this a little later.

Let us now see what the modern treatment of acute pleurisy is: The fever, which is the first manifestation of the disease, is combated from the start by sulphate of quinine and antipyrine; for treating the pain, the physician of to-day exhibits sometimes a certain amount of therapeutic audacity, for if the suffering is too intense he resorts to the hypodermatic injections of morphine. By this he hopes to strangle, as it were, the advanced sentinel which is denouncing the localization of the disease; while the effusion is slowly but surely taking place within the cavity of the pleura, simply because nothing is done against the local hyperæmia which is to give origin to the

fibrinous exudation and the serous secretion. There are other practitioners who do still less; who observe the doctrine of the absolute expectant treatment, practitioners whom I call volunteers of the doctrine of contemplation, and who allow the sero-fibrinous secretion to take its course, maintaining that acute pleurisy is a cyclical disease which must terminate spontaneously in 2 or 3 weeks.

I consider it my duty to oppose such a doctrine; in the first place, because you cannot remain indifferent, even if the disease is not shortened by it, towards a means by which you can diminish the pain and thereby the suffering of the patient; secondly, because, in my opinion, the disorder may be shortened; and finally because the inflammatory disease can be rendered less serious by the antiphlogistic treatment.

My learned friend, Sée, calls attention to the fact, in support of his doctrine, that 60 out of 100 cases of acute pleurisy are either tubercular or pretubercular. I confess that this argument is somewhat contrary to the views already expressed; but I still believe that, even in such cases, an active interference is necessary. I will also say that hæmatisis being lessened by the pulmonary tubercularization, it becomes urgent to endeavor to prevent a new diminution of this blood-making process, which necessarily results from the occurrence of the pleural effusion.

It is precisely the non-application of the antiphlogistic treatment, gentlemen, at the beginning of an acute pleurisy, which permits the formation of these large serous collections, and for which we are obliged afterwards to practise thoracentesis—an occurrence which I deplore, and by which a medical is changed into a surgical disease.

What I have endeavored to show is: (1) that the serous effusion may be stayed; (2) that it may be entirely prevented; (3) that a moderate effusion (say from 500 to 1000 grammes, for example) is still a condition for the justifiable application of revulsion, and that thus piercing the chest may be avoided, especially if the disease has not reached its 24th day; (4) that, finally, if the effusion is considerably large (that is, from 1,800 to 2,000 grammes) thoracentesis must be resorted to, even before the 24th day, and preferably by the aspiratory method. In this I am in accord, in all points, with my friend Dieulafoy.

I have before remarked that during the first half of this century, in 32 cases of acute pleurisy only 1 death occurred, and that the absorption of the effusion was rapid. Now, let us see what the facts are in our days:

The serous effusions are not only more and more abundant, but the abundant effusions are more and more frequent also, and these are not only more serious but quite purulent in a large number of cases; so that the operation for empyema has become more and more frequent. Two distinguished surgeons, Gosselin and Richet, have assured me that their surgical life, regarding pleurisy, could be divided into two distinct periods; in the first one, embracing a lapse of from 20 to 30 years, they never had occasion to practice operations for empyema; while during the second one, which corresponds to the present epoch, they have practiced such operation twice or thrice a year. Nélaton, according to Dolbeau, practiced, at an advanced period of his life, the operation for empyema.

Now, there is at least a singular coincidence between this aggravation of pleurisy, the necessity of our having often to perform thoracentesis or an operation for empyema, and the treatment of modern times. I do not hesitate to say that such is not a coincidence but a correlation.

Louis has asserted that nobody ever died from acute pleurisy; but this proposition is too absolute. Laennec affirmed that death was rare, but he does not mention a single case of sudden termination as a consequence of this disease. We have already seen that only 1 death was recorded in the 32 cases of Andral and Bouillaud, giving a mortality of only 3 per cent. I have studied the proportionate mortality from pleurisy, at the Hôpital Necker, during the years 1889, 1890 and 1891, and I find the following statistics: In 1889, 4 deaths in 60 cases; in 1890, 2 deaths in 44 cases; in 1891, 7 deaths in 70 cases; all of which give an average mortality of 7 per cent. during these 3 years, the double of that presented by Andral and Bouillaud.

Let us now consider the question of sudden death. This has been attributed, and not without reason, to the abundance of the effusion, that is, to the generalization of the disease over the pleura. In an interesting work, one of our distin-

guished hospital physicians, Talamon, has reported cases of sudden death by syncope, not only in patients in whom the effusion was of a minor importance, but also in two cases that had generalized fibrinous adhesions. Talamon has investigated the cause of death in such instances. He ascribes it particularly to the rapid formation of a thrombus of the artery or of the pulmonary infundibulum, since the post-mortem of such cases did not offer a satisfactory explanation of the mortal syncope. I believe, myself, that in those cases, in which the disease is so generalized, the inflammatory process has gone so far as to produce diffused adhesions, adhesions which affect the posterior pulmonary plexus, and thus cause, by a reflex mechanism, an inhibition of the cardiac plexus.

I will not say much regarding the part which the nerves play in acute pleurisy. In the first period of the malady the intercostal or the phrenic nerves are deeply affected, and at an advanced stage a functional trouble comes on, followed soon after by inhibition of the nervous mechanism of the heart and consequent death.

There is, therefore, danger in permitting the generalization of the pleuritic affection, because it may result in the production of serous effusions and adhesions, and, in both cases, in an interference with the function of the pulmonary plexus. It becomes, then, necessary to avoid the development and the generalization of the pleuritic inflammation.

To resume: in a frank, acute pleurisy, due to cold, and occurring in a robust and otherwise healthy adult, the effusion may, during the initial stage, be stayed or avoided. Later, when the period of effusion has been established, during the first two weeks, if the effusion is considerable, a cure can be obtained through the application of wet-cupping, followed by one or two blisters. It is understood, of course, by a rational necessity, that the patient may be subjected to diet.

I have said that the serous effusion may be prevented at the beginning of the disease. I can cite cases of this kind to prove my assertion. For instance, to a young lady I advised sulphur baths for rheumatismal pains from which she was suffering, but forgot to state to her that the water should be warm. She took a cold bath. In about ten minutes she

began to experience intense chilly sensations which obliged her to get out of the tub. Soon afterwards she was taken with severe chills, a general malaise and a pain in the side. She then sent for me. I arrived about five or six hours after the bath had been taken, and found the patient suffering from fever, an intense pain in the side, and great dyspnoea. On examination I detected a slight friction sound due to a fibrinous exudation, but there was no effusion. I immediately applied wet-cupping, which was followed by a rapid diminution of the pain and of the dyspnoea. I saw the patient in the evening; on the following morning she had no effusion, but I could still notice the pleuritic friction sound. I then applied a blister 10 by 8 centimeters in size, and six days afterwards, the patient had completely recovered, without any effusion having taken place.

I have previously said that when the effusion is about 500 to 1,000 grammes, revulsion will be sufficient to effect a cure. I agree with Dieulafoy in that when the effusion goes in amount above the figure just mentioned, that is, 2,000 grammes or more, so that displacement of the viscera is apt to occur, puncture of the chest becomes necessary. In these cases I have seen (and others have observed analogous results) re-absorption to take place, followed by a cure, through the successive applications of blisters before the third week of the disease had passed, and while fever is still present. In this respect I am in absolute accord with Hardy and Constantin Paul. I could cite a large number of cases of this nature, but I will only relate the following one:—

A very distinguished Paris physician, 50 years of age, suffered an attack of acute pleurisy on the 25th of June, 1881. On the 18th he was asked by some of our learned colleagues to have the chest punctured, calculating that there was two litres of serous effusion already collected. The sick physician stoutly refused, and, on the 19th Professor Hardy was called in consultation, and he (Hardy) advised the application of a large blister. A few days later, having returned from a professional visit which had prevented me from seeing this patient at the beginning of the disease, I told him that in the presence of the abundant exudation, and owing to the persistence of the fever, thoracentesis was urgently

called for. He refused again, and requested me to apply blisters. He had, in all, eight blisters, and "thanks to these derivatives," he wrote to me sometime afterwards, "he had, by the 30th of July, completely recovered." The disease lasted forty-five days, after which our patient entered again into the enjoyment of good health, and was once more able to attend to his own patients.

Now, gentleman, I have cited this case not expecting you to act similarly in a parallel instance, but to show you that when thoracentesis appears to be most urgently needed, it can be avoided if the disease has not gone beyond the twentieth day.

You see then, gentlemen, that, agreeing with my learned friend, Hardy, I must protest, with proofs to support us, against the abandonment of the antiphlogistic treatment, especially at the onset of acute pleurisy.

With Constantin Paul, I wait, to practise thoracentesis, until the fever has subsided, and for the disease to have gone beyond the 20th day, because before or at this period re-absorption is possible. Like Proust, and following the example of Troussseau, I am in the habit of evacuating the liquid at once and in a slow manner. Finally, like Dieulafoy, I practise the operation, even if fever is present, when the effusion is so abundant as to cause displacement of the viscera. I will insist upon the danger arising in the generalization of the pleuritic inflammation, which may be the cause of sudden death, and also upon the urgency of practising thoracentesis in such cases.

In conclusion, I will say that to-day, generally, the study of the pathogenic cause makes us forget that of the morbid action. Particularly in acute pleurisy, we have not evidently ascertained the nature of the morbid action, that is, whether this is due to cold or to infectious microbes. We are only familiar with the processes that occur, that is, with the stage of hyperæmia, the stage of exudation, and the secretory stage. Now, during the pre-secretory period, which may last from 12 to 24 hours, we have, if called in time, sufficient opportunities to act in order to prevent or stop the occurrence of the effusion. This is what I have tried to demonstrate to you.—Translated from *Le Bulletin Médical*, April 27, 1892.

Communications.

METHODS OF MODERN DERMATOLOGY.*

BY LOUIS F. FRANK, M. D.,

MILWAUKEE, WIS.

The history of dermatology is as ancient as the history of medicine in general, but it is impossible to make a correct account of the literature of cutaneous medicine, owing to the confusion which has existed in the nomenclature of this branch from the very oldest times to the present. Hippocrates can be considered as the founder of Grecian dermatology, other investigators after his time are Cornelius Celsus, Pliny, Galen, Lorry Plenck and Willar of the last century, and an array of prominent writers of this century. It was reserved for the genius of Hebra, to examine critically the enormous material of dermatology, to discard useless material, strengthen and uphold true principles, to properly and scientifically classify dermatological diseases and their forms. We must admire the simplified nomenclature and clear logic of Hebra, his gift of observation and his precise indications for the employment of appropriate remedies, which were in part already in use and in part were first introduced by himself. Assisted by the fertile minds of a Rakitauský and Ikoda, who built up a new school of pathological anatomy, Ferdinand Hebra became the founder of modern dermatology. Since that period most noteworthy changes have taken place in its therapeutics; the principles first proclaimed by the Vienna school under the general leadership of Hebra, were remodeled with every influential discovery made in the last 20 years, and every new discovered fact and the list of remedies enlarged. And this progress is due to two factors: 1. The better knowledge of the causes of skin diseases, in no small degree due to the perfection of the microscope. 2. The discoveries of new remedies and methods in dermatology. Of these I wish to speak.

Among the most important and efficient enrichments in modern dermato-therapeutics are the salve and plaster-mulls of Unna. The principles which led to this important progress were those of modern antiseptics,

* Read before Milwaukee Medical Society, April 26, 1892.

aiming at the complete rest of the skin, prevention of friction from clothing, complete exclusion of outer air and its detrimental action on the skin. The basis of this dressing primarily consisted of undressed cotton of various lengths and thickness, which were drawn through an ointment constituted of mutton tallow. In this manner Hebra's and Wilson's ointments were first made. These mulls were covered on both sides with the medicated ointment, and only since of late but on one side. The dressing was adapted and held in place by cotton or mull bandages. It is evident that a dressing of this kind facilitates the treatment of ambulatory patients, even if the skin lesion should be a very extensive one. Especially eczemas in the region of the anus, scrotum and axilla and lower extremities can be treated with pronounced success. I regard this treatment of eczema of the nostrils and ears (external auditory canal) as the very best and efficient. In 1882, a most decided progress in the plaster-mulls was made by Unna, when he introduced the so-called gutta-percha plaster-mulls, which meet any demand of a continual and impermeable dressing. It has the great advantage of not irritating the skin and being very adherent. In many persons of irritable skin you will have found that the application of an ordinary adhesive plaster will cause dermatitis and eczema of the affected and adjacent parts. An important factor likewise is the macerating action of the gutta-percha and similar material. Already Hebra used rubber gloves, stockings, caps, and other articles of clothing in the treatment of chronic eczemas, on account of the macerating effect produced by the same. They are likewise of great value in all conditions of hyperplasia of the epidermis and keratoses, due to a variety of causes, also in certain forms of psoriasis and the obstinate papular syphilides as they occur in the palm of the hand and soles of the feet. A vast number of medicinal remedies are combined with the salve-mull and gutta-percha plaster-mull, the firm of P. Beiersdorf & Co., Altona, Germany, manufacturing twenty-seven of the former and 131 of the latter.

Some years ago Prof. Pick, of Prague, suggested the use of gelatine as a vehicle for various medicaments in dermatological practice. He employed a mixture of gelatine and water over which, after its

application to the skin, was smeared a thin layer of glycerine. Unna and Beiersdorf combined the gelatine and glycerine directly and they found that a definite relation must exist between the amounts of glycerine, gelatine and water taken and the percentage of drug employed. The formula is as follows:

R	Zinc oxyd.....	30.0
	Gelatine alba.....	40.0
	Glycerine.....	50.0
	Aqua.....	90.0

M. The gelatine preparation is prepared for use by being melted, the tin containing it being placed in a vessel of boiling water—and painted on the parts with a stiff brush. The jelly is then covered with tissue paper or dried with cotton-batting which forms a thin coating. As much water is added as is necessary to form the proper consistency. It is a very valuable preparation where a complete protection from external influences is demanded as we find it in many forms of eczema, particularly the squamous variety. The action of the gelatine can of course be but a very superficial one as its constituents do not penetrate the epithelial layer and resorption is impossible. However, as a protective dressing its value cannot be over estimated. Any medicinal remedy can be combined with it, particularly ichthyol, sulphur, sublimate, acetate of lead, chrysarobin, pyrogallol, etc.

For the treatment of isolated lesions of the skin the treatment by salve-sticks and paste-sticks has been advocated by Unna and Brook. The paste-sticks are soluble, the salve-sticks insoluble. The basis of paste-stick is starch, sugar and mucilage of tragacanth; the basis of the salve-sticks consists of

R	35 pts of wax
	55 " " olive oil
	10 " " oil soap free of water.

They are useful in localized eczema, mycoses, lupus, syphilides, parakeratoses and hyperkeratoses, anomalies of pigmentation, ulcers, etc.

Medicated soaps so far as they have been found up to date in market are articles of but slight value, and to Unna again belongs the credit of having obtained preparations which fulfill the just demands of dermatologists. The basis for the medicinal agents consists of soap containing a surplus of fat. It is prepared out of beef tallow and a mixture of two parts of soda-lie and one part of potash-lie; to the mass

is added a sufficient quantity of olive oil that about 4 per cent. remains unsaponified, which is the surplus fat.

Although the scientific treatment of skin diseases by soaps has been up to date but little in use compared with the treatment by salves, plasters, and pastes the advantage of their application is self-evident. This method is not only justified but absolutely indicated in all those cases where the diseased skin is rich in fat due to an increased secretion from the sebaceous glands and sweat ducts. In all these cases it would be imprudent to add more fat in form of an ointment to an already fatty skin, but to use a soap which will form an emulsion with the superfluous fat of the skin. By removing this fat which is on the surface and also that which fills up the orifices of the glandular ducts the medicinal remedy incorporated in the soap is allowed to penetrate and act on the inner walls of the sebaceous and sudoriferous ducts. This is of prime importance as we know that especially in parasitic diseases the source of the affection is often deeply buried in the glandular organs of the skin, where it can develop anew, extend to the surface and cause a so-called relapse, which really means that the germ of the disease has not been completely eradicated. The treatment by soaps is thus far particularly indicated in diseases of a parasitic nature, in tinea, sycosis, acne, psoriasis, etc. With regard to their chemical properties soaps are divided into

Alkaline soaps (with a surplus of free alkali.)

Neutral soap (in which all alkali is combined with the particular fat acid.)

Acid soaps (with a surplus of free weak acid.)

As far as my experience goes in the treatment of skin diseases by medicated soaps the results have not been as satisfactory as proclaimed, however, I use them very frequently regarding them as a most valuable expedient in the treatment of many skin lesions.

The action of drugs applied to the skin in the form of spray is a very energetic and applicable one. The practical facts harmonize with the physiological fact that the power of resorption of volatile substances by the skin is a great one, which is especially true when the skin is denuded of its epidermis. This method is especially indicated where the skin or mucous

membrane is free of access, as the external auditory channel to the tympanum, the nose and pharynx, the urethral and anal mucous membranes; likewise fissures as caused by eczema, psoriasis, syphilides or the natural folds behind the ear, the nipple, the fingers and toes. Certain forms of mycoses as pityriasis vesiculæ and tinea tonsurans are readily cured by a spray of a 10 per cent. chrysorubin solution.

An important part of recent therapeutics of the skin is played by mechanical treatment by means of Valkmann's spoon, the sharp and pyramidal prong fastened to the spoon, as modified by Anspitz, and the flat, double-cutting lancet-needle for cutting out vessels in the skin; the various apparatus for the same purpose, finally the electrical needles and combination of needles for the destruction of the hair-follicles, the latter being especially recommended in America in recent times. In many skin diseases, especially nevi, pointed condylomata, warts, and superficial epitheliomata, pustula, acne and sycosis, lupus, tuberculosis and erythematoses, mechanical treatment either alone or combined with other medicinal agents constitutes a very useful, occasionally the sole therapeutic method, attended with good results.

It may be of interest here to allude to an apparatus of late devised for producing local anaesthesia. I first saw it used in the clinics of Prof. Besnier; it consists of a cylinder containing chloride of methylene gas under high pressure, which escaping rapidly liquefies, causing local anaesthesia. It is without doubt a great progress in local anaesthesia, particularly as injections of cocaine are liable to cause alarming symptoms at times, and the use of the ether spray combined with the actual cautery is liable to cause explosion. The local action of chloride of methylene is similar to that of ether, but more rapid and intense. It first causes a local irritation, then after a few seconds a diminution of sensibility, the skin turning white and anæmic and covered with frost, which then is the proper time to operate. If the anaesthesia is carried too far there is great danger of causing deep-seated gangrene.

The opening of abscesses, felons, excision of chancroids, the operation for phimosis, opening of pustules, extirpation of atheromata—in fact all superficial minor operations form the indications for its use. In dermatology it is applied principally

for scarifications, scraping with the sharp spoon in case of lupus and similar minor operations. In conclusion I will draw your attention to the Micro cauter, a modification of the Paquelin cauter, proposed by Dr. Unna. It consists of the ordinary cauter point to which a copper wire is affixed which enables the heat to be conducted to a very small point. I employ it principally in naevi and in dilated vessels as we find them in venous lesions, especially acne, rosacea, telangiectases, lupus, etc.

After the conclusion of Dr. Frank's paper, the following discussion occurred:—

Dr. H. H. Sercombe: How much of the surface is anesthetized by the apparatus you have shown us?

Dr. Frank: A spot about as large as a dollar.

Dr. S. W. French: Have you used colodion on the skin?

Dr. Frank: I have never used it in place of the gelatine, but I think the latter preferable.

Dr. J. A. Bach: I should like to ask, in cases of eczema of the internal auditory canal, whether the doctor uses plasters or ointments.

Dr. Frank: I employ salve-mulls, especially the double sided ones, cut out about the length of the canal, rolled up, put in and pressed around on all sides, especially through the nostrils.

Dr. D. J. Hays: In regard to the gelatine treatment the doctor spoke of, I have used that during the past three years with remarkable success in some cases of squamous eczema. Cases that have resisted treatment for years rapidly improve under this method. The gelatine is simply painted on the part affected, the application being allowed to remain for three or four days or a week. The plasters cannot be applied in all places, but where they can be I have met with remarkable success.

I regard the ointments generally that are put up in our apothecary shops as doing more harm than good. That, at least, has been my experience with them. They are rough and irritating to the skin, and nine times out of ten are without good effect, but treatment with these plasters, and especially with gelatine, applying the latter with a brush, will cure cases that have resisted all other kinds of treatment for years.

Dr. French: Do you confine yourself to

the remedies you have mentioned or do you use lotions also?

Dr. Frank: Of course I use lotions and other remedies. I do not limit myself to the remedies I have spoken of, but my subject is Modern Methods of Dermatology, and these methods have all been adopted within the past few years.

THE USE OF HOMATROPINE DISCS IN REFRACTION.

ARTHUR D. MANSFIELD, M. D.

ASSISTANT SURGEON AT THE PRESBYTERIAN EYE, EAR AND THROAT CHARITY HOSPITAL, BALTIMORE, MD.

It often becomes necessary in testing the refraction of an eye to temporarily completely paralyze the accommodation, thus rendering the eye incapable of exerting any voluntary effort toward reading or near work of any kind being accomplished. When an eye is in a condition to only appreciate distant objects then we can find the defects much more readily than when the accommodation is allowed full play and scope.

In the majority of eyes demanding aid in visual defects we can dispense with the use of a mydriatic and can find out the defect of such an eye unaided, but in some cases, the number varying, a mydriatic is demanded and the indications for it absolutely positive. Now comes the important question, what mydriatic shall we use? The great objection to mydriatics is that the mydriasis lasts too long, entails too much discomfort upon the patient, renders an important organ useless; and in those who depend upon their vision for their livelihood the question is a serious one. The demand on the part of the eye for aid in the shape of properly adjusted lenses is necessary, and to accomplish this the paralysis of the spasm of the accommodation is also necessary. Then what shall we do? We want a mydriatic that will paralyze completely the muscular ability of the eye, yet at the same time allow the eye to recover quickly from the influence of such an action. Before a mydriatic of such a character was discovered, their use for refraction was a serious matter to the patient, but in homa-

tropine, we find a mydriatic causing but little discomfort. Homatropine has been used in many forms—the aqueous solution, the oily solution, and the discs of homatropine hydrobromate combined with the hydrochlorate of cocaine.

My intention is to draw particular attention to the use of the discs of homatropine and cocaine, yet I cannot refrain from mentioning the other forms in which we use this mydriatic. From the aqueous solution we get excellent results if we will only wait long enough and instill the drops with sufficient frequency. With the instillation of a solution of homatropine mydriasis and complete paralysis of the accommodation do not follow until 30 to 45 minutes have elapsed, which is rather longer than the pressure of hospital work will allow; what we need is something that works more rapidly. Such a substance was thought to be found in the oily solution of homatropine but my experience has been very limited and what I have had has been rather unfavorable on account of its setting up considerable inflammation in the conjunctive and producing such lachrymation and photophobia as to render its use absolutely painful. My experiences may not accord with that of some others. Nevertheless I have abandoned the oil for another form from which I have had most pleasant and brilliant results.

We all are aware that with the least spasm of the accommodation where astigmatism occurs that it is almost useless to attempt to properly adjust glasses to correct the faulty meridian, as the faulty meridian will migrate in as many different angles as are shown on the astigmatic chart. To bring out the only faulty meridian (or meridians) it is necessary to use the mydriatic, and, as I have already endeavored to point out, homatropine is the substance best adapted to do this, and the form in which it is most efficacious is in discs as prepared by Jno. Wyeth & Bro. of Philadelphia. These ophthalmic discs are very small, only about one-eighth inch in diameter and as thin as a piece of writing paper, made of the purest gelatin, devoid of all irritating substances, and each contains hydrobromate of homatropine gr. $\frac{1}{16}$, and hydrochlorate of cocaine, gr. $\frac{1}{16}$. The presence of the cocaine is to facilitate the absorption of the homatropine by the cornea, the reason being that cocaine exerts a peculiar disintegrating effect

upon the epithelium of the corneal substance, thus allowing the homatropine to come in closer contact with the nerve fibres of the cornea which ramify in all directions.

The discs when placed upon the everted conjunctiva of the lower lid, and the lid with the disc allowed to return to its proper position. At once there is a feeling of discomfort, due of course, to the presence of the foreign body, which discomfort lasts but a short while, for as soon as the disc dissolves the uneasiness disappears. The dilatation begins almost immediately and in from 7 to 10 minutes the mydriasis is complete. It is not in all cases that homatropine will give us complete paralysis of the accommodation, there are some cases, as we all know, who have much refraction to work, that require the continued use of atropine itself. But aside from such cases the use of the homatropine will give excellent results, and I particularly recommend to the attention of my readers so disposed to follow my advice to give the gelatine ophthalmic discs a trial.

My reasons for preferring the discs to either the aqueous or oily solutions of homatropine are as follows: In the first place we have a definite quantity instilled into the eye and hence we obtain a definite result if the discs contain the definite amount, and we have every reason to believe that they do.

Secondly, the discs being dry are not subject to the same fungoid growths and changes in composition to which the aqueous solution is subjected. Consequently the discs can be kept for any length of time, while age impairs the efficiency of the aqueous solution.

Thirdly, the action of the discs is more rapid by half, in some cases by two thirds, than the solution of the drug.

Fourthly, in using the solution there is always more waste than in the form under consideration, which is quite a consideration in the use of such a drug as homatropine. The drug is a useful one no matter in which form we use it, and cannot well be dispensed with in our present work, but the desires of the age are always for the better, no matter how small the difference may be, especially when the difference is a question of time combined with efficiency.

129 So. Broadway, Baltimore Md.

A CASE OF CRUSHED KIDNEY CAUSED BY A RAILWAY ACCIDENT.

By HERMAN MYNTER, M. D.,

BUFFALO, N. Y.

The following case is of peculiar interest, as the injury is one very frequently produced by railroads and very fatal in its consequences.

On Jan. 27, 1891, I was called to Oil City, Pa., by a dispatch, stating that a man had been severely injured by a railroad accident, and that probably a laparotomy would have to be performed. On arriving, late in the evening, I saw the patient, Mr. A. Wood, aged twenty-two, and learned from his attending surgeons the following history:

Late in the evening on Jan. 23, four days previously, he was caught obliquely between the bumpers while coupling cars. He stated then that he was not seriously hurt and could continue work as brakeman on a freight train. He actually did ride thirty miles on the train, and then had to give up on account of faintness, pain and vomiting, and was brought back to Oil City, where Dr. Coulter was called to see him on Jan. 24, at 3.30 a. m. He found no visible injury, no fracture of pelvic bones, no particular tenderness in abdomen, except in right iliac region, where he had considerable pain by pressure. No ecchymoses were present anywhere. At this time he was considered seriously hurt. During the day (Jan. 24) the patient could not urinate and was in great distress on that account. He managed at last to empty his bladder and the water contained a great amount of blood. After that his bladder was emptied with a catheter three or four times a day and the urine continued to contain more or less blood.

On January 26, the temperature began to rise, being 102.5° but afterward gradually receded to 100.5°. The pulse ranged from 100 to 108. On the same day tympanitis commenced, although not excessive. Some flatus were passed on January 29. No hicough. On examination the patient was seen to be a strong, healthy young man. Temperature, 102°; pulse, 108, full and regular.

Considerable meteorismus was present, with tenderness in right iliac region. No

particular tenderness in left side of the abdomen. The meteorismus prevented a careful examination of the abdomen. Over the right lumbar region a diffuse ecchymosis and some fullness and muscular rigidity were seen, and he was very tender upon deep pressure here. There were slight ecchymosis around anus and perineum.

The urine was normal in quantity, but intimately mixed with blood, and of a dark, dirty color. It contained no coagula of blood. His bowels had not moved, he having been kept under the influence of opium since the injury.

The question of diagnosis was not discussed. It was evident that the man was seriously hurt, but I thought we could exclude any injury to organs in the abdominal cavity. A crush or rupture of the bowels would probably have terminated fatally before the time by diffuse peritonitis, of which there were no signs. True enough, he had considerable meteorismus, but not more than could be accounted for by a slight traumatic peritonitis and the continued opium treatment. The normal quantity of urine, of course, excluded rupture of the bladder, not to mention the absence of diffuse peritonitis. A rupture of spleen or liver would probably have terminated fatally by internal hæmorrhage in a short time.

The ecchymosis over the right lumbar region, on the other hand, the deep-seated pain and swelling here, the muscular rigidity, the intimate mixture of urine with blood, the fact that he vomited immediately after the accident, but otherwise was able to travel thirty miles and then first became faint and had to give up work, and lastly the tenesmus of the bladder pointed directly to the right kidney as the seat of lesion, and I thought I was justified in diagnosing a rupture of this organ.

The next question, whether he could be removed to Buffalo, as his family insisted upon, was settled with the diagnosis, and Dr. Coulter and I left that same night with the patient on a special train, and arrived at Buffalo at 6 o'clock on the morning of January 28, the patient having stood the journey well. I had him transferred to the Emergency Hospital, and gave orders to have him take ʒi of epsom salt immediately, and ʒss every hour afterward till copious evacuations occurred, and to have him transferred to the Sisters' Hospital

for operation at 11 o'clock. On his arrival there he had several copious evacuations, with the result that the meteorismus had disappeared. An indistinct deep swelling, with intense tenderness by pressure, could now be felt in the right iliac region. Under ether narcosis, exploratory incision of the right kidney was made in the usual way by an incision four inches long and two and one-half inches from the spine, extending from twelfth rib downward toward posterior superior crest of the ilium. Having reached the lumbar fascia, the usual yellowish-white color was seen changed to an intense dark color from infiltration of blood. On passing through this fascia a large cavity was opened, containing about a pint of dark bloody fluid and coagula. The lower half of the kidney was found crushed to a pulp, and felt very much like an epithelioma of the uterus in the process of disintegration.

The question of nephrectomy was now in order, but bleeding from the crushed kidney was so copious by the slightest touch or manipulation, that all I could do was quickly to remove the blood coagula, disinfect the cavity with corrosive sublimate and then pack it firmly with iodoform gauze, over which an antiseptic dressing was applied. One or two results were possible. Either the crushed parts might become eliminated by and by, and under favorable circumstances recovery might take place, or else, the bleeding having stopped and inflammatory thickening and adhesion having occurred, a nephrectomy might, later, be performed.

On Feb. 3, urine was noticed to pass through the wound. The dressing was changed without bleeding, and a new one applied. On the same day the water commenced to clear up, although still containing considerable pus. He gradually improved, the large cavity contracted more and more, the urine became more and more normal, the crushed parts of the kidney came away by irrigation, and on March 16 he left the hospital with the wound healed, with the exception of a small fistula, through which scarcely anything was discharged. The fistula has since healed completely, and the patient is in excellent health.

General Remarks.—I desire to add a few remarks on the subject of crushed kidneys. In regard to the etiology of ruptured and crushed kidneys, blows, falls

and crushes are mentioned as the most frequent causes, not considering the cases which are produced by gun-shot wounds, etc. A quite frequent cause, probably the most frequent, are crushes between the bumpers of railroad cars. In "International Encyclopædia of Surgery" two cases are mentioned. One was that of a man aged twenty-one, who was struck by the bumper of an engine. He vomited and complained of great pain beneath the ribs. Next day bloody urine was noted, which gradually increased, so that great tenesmus of the bladder occurred from coagula in the bladder. A dull swelling formed in the left side of the abdomen, tympanitis and delirium supervened and death occurred on the twenty-sixth day. The left kidney was found ruptured across the middle and the lower segment crossed transversely by numerous fissures. A large cavity was found surrounding the broken kidney, filled with grumous, offensive blood, clots and urine. In the peritoneum, forming the anterior wall of this cavity, there was a ragged rent in a thin slough, through which offensive serum was found to exude into the peritoneal sac.

The other case died on the eleventh day, a tumor having been observed on the left side, with similar symptoms as in the previous case. The left kidney was found completely divided through the pelvis, and the two halves widely separated by blood and urine, which reached behind the peritoneum as high up as the diaphragm and as low down as the insertion of the psoas muscle on the femur. A kidney may become completely torn through, either transversely or longitudinally, there may be several small surface tears, or it may be pulpified, as in my case.

The first and principal danger is the bleeding, which gradually may reach such proportions that strangling of the peritoneum from pressure occurs. If a large branch of renal artery is torn death may occur quickly. If the patient survives this danger he stands an excellent chance of succumbing to a perinephritic abscess. Can you imagine a better chance for the development of a genuine abscess than a crushed kidney with a collection of blood and urine in the loose, fatty and easily destroyed tissue in the retroperitoneal space?

It is true that there are a number of recoveries from ruptured kidneys on record,

the principal symptoms of which were hæmaturia, but, to say the least, it is questionable whether they were cases of ruptured kidney! Hæmaturia is not necessarily a symptom of ruptured kidney, occurring, as it does, from contusions, renal calculus, acute nephritis, etc.

On the other hand, a ruptured kidney may exist without hæmaturia if the ureter becomes plugged by a clot or completely torn across, so that neither blood nor urine can reach the bladder. In regard to the symptoms I can give no better description than that of Henry Morris, surgeon to the Middlesex Hospital in London:

"If after the abdomen has been run over or the person has fallen or been struck on the abdomen or loin, faintness, coldness, vomiting and abdominal pains follow; if on the day of, or the day after, the accident, and whether the catheter be required or not, the urine is found to contain a quantity of blood and blood clot, and if after several days blood clots continue to pass, or pus as well as blood is voided in the urine; if, moreover, there is pain along the course of the ureter, with retraction of the testis, or a rigid and prominent state of the muscles on one side of the abdomen, with frequent desire to micturate; or finally, if a tumor, dull on percussion, forms in the loin, or lumbar or hypochondriac regions of the abdomen, accompanied or not with signs of local peritonitis—there are safe grounds for believing that either the kidney or its pelvis has been ruptured."

The prognosis, at best, is doubtful, and the mortality great. Dr. Otis gives statistics of 27 cases, of which 16 died; a mortality of 59 per cent. Maas gives another table of 71 cases, of which 34 died; a mortality of 48 per cent. Both added together give 98 cases with 50 deaths; a mortality of 51 per cent., all for subperitoneal injuries.

In compound injuries, by gun-shot wounds or penetrating instruments, the mortality is still greater. In the "Medical and Surgical History of the War" 78 such cases are mentioned, 52 of which died; a mortality of 67 per cent. In none of these were operations performed.

When we, lastly, consider the treatment, then I believe that very little reliance can be placed in the usual administration of opium, ergot, astringents and cold applications, except in the lightest cases, which would probably recover without treatment.

Considering that an exploratory incision of the kidney region under antiseptic precautions is an operation absolutely devoid of danger, and that by no other means are we able to satisfy ourselves of the amount of injury done or prevent dangerous and fatal complications from occurring, I am strongly in favor, with Simon, of employing this measure as a preliminary step in all cases where there are symptoms of ruptured kidney. If we should find the diagnosis wrong or the injury less than we suspected, no harm will have been done. If right, we are in a position to judge about the severity of the lesion, and the means to be used in order to meet the dangers, be this ligation of ruptured arteries,—nephrectomy, if possible, in completely crushed organs, or simply, as in my case, removal of clots of blood, disinfecting of the cavity, and packing with iodoform gauze, leaving the wound open for drainage, and referring the question of nephrectomy to a future time.

That even in such a case nature can accomplish wonders, and that nephrectomy may be superfluous, is well shown in this case.

THE VISUAL FIELD IN EPILEPTICS AND MENTALLY DEFICIENT PATIENTS.

Lombroso (*Rec. d'ophthal.*, August, 1891) draws the following conclusions from his observations: 1. The visual field is remarkably limited in epileptics and idiots. 2. There is a constant irregularity at the periphery of the field, and the line of demarkation appears irregular and sinuous, sometimes forming actual peripheral scotomata of very inconstant relation. 3. The field is more limited on the right side in the lower hemisphere, and on the left side in the upper hemisphere, thus forming a partial hemianopsia to the right below and to the left above. This he calls a partial heteronymous vertical hemianopsia. 4. In some cases there was an extreme limitation of the field due to neuroretinitis. 5. In all, the field for color was limited, its form following constantly that for white, but more or less regularly. 6. The field for blue and that for red cross at different peripheral points. 7. In almost all cases the ophthalmoscopic examination was negative. 8. The visual acuity was entirely independent of peripheral vision.

CASE OF PERITYPHLITIS.

By J. P. TUCKER, M. D.,
OVERTON, TEXAS.

I was called April 17th, 1891; to see Mr. D. J.'s little son, aged fourteen years. I examined the patient and found considerable tenderness in the right iliac fossa; patient complained of an excruciating pain all the time; temperature 102° , pulse 130, respiration 38. I gave 5 grains of calomel and $\frac{1}{2}$ grain of pulv. opium, 5 grains of antifebrin to reduce temperature, then 3 grains of sulphate of quinine, every four hours, $\frac{1}{8}$ gr. sulphate of morphine as required to relieve pain, turpentine stupes over bowels, but my little patient continued to suffer pain. On the morning of April 26, I discovered an abscess about two inches below and $1\frac{1}{2}$ inches to the right of the umbilicus. I explored the abscess and found pus deep-seated. I made a free incision through the abdominal wall into the sac; at the time I operated I think it discharged 20 ounces of thin milky-looking pus, the odor of fecal matter. The father of the little patient says he is satisfied it discharged a gallon of pus in all it discharged in four weeks. I put in a drainage tube after operation; the treatment was iron, quinine and good rich food in the form of fluids, with morphine as required to relieve pain; bowels kept in soluble condition. The little patient says about three weeks before the abscess developed, that he jumped off a stump and the end of a hoe handle struck him in the side where the abscess formed; about four weeks after it ceased to discharge, the little unfortunate patient went out horseback riding with his brother and they ran a horse race, the horse stopped suddenly and and threw him on the horn of the saddle and another abscess developed in the same place, and it opened spontaneously. This time it discharged two weeks.

Etiology.—Perityphlitis is usually the result of extension of inflammation from the vermiform appendix or its rupture from ulceration. It may be due to the extension of tubercular, typhoid, or dysenteric ulcers in the cæcum and to the lodgment of foreign bodies in the vermiform appendix. Caries of the spine or of the pelvis have induced it. Traumatism is an occasional cause; it is rarely of spontaneous origin. Of the symptoms in a few

instances of perityphlitis, especially those supervening on typhlitis, there will be a history of colicky pains which radiate outward from the cæcal region with more or less irregularity in the action of the bowels. There is pain in the thigh accompanied by numbness and a sense of formication in the right lower extremity, due to pressure of the tumor upon the nerves. This pain is deep-seated and much increased by flexing the thigh upon the abdomen. Rigors and febrile movements are usually slight. In extensive perityphlitis, the patient cannot raise the right thigh, either on account of the pain or from interference with function of the nerves from the pressure. When the abscess is of large size there may be oedema of the limb, the parts in the vicinity of the cæcum are very tender to pressure, and the patient usually lies on the right side with his thigh semi-flexed so as to relax the psoas and iliac muscles. As the abscess increases in size there is in adults constipation and a tendency to vomit; in children the bowels are commonly loose and pain in the stomach will have been an early and prominent symptom. When a perityphlitis arises as a typhlitis is disappearing, a painful tumor more deeply seated than in typhlitis will make its appearance. The little patient referred to finally made a good recovery.

HYDROGEN PEROXIDE AS A DISINFECTANT OF WATER.

Dr. Althoefer, after giving references to the literature of the subject, gives his researches on the disinfectant power of H_2O_2 dissolved in water. He finds that the addition of 1 per 1,000 to ordinary drinking water, to drinking water containing sewage, or to water containing typhoid bacillus or cholera bacillus is quite sufficient to destroy the various saprophytic and pathogenic organisms contained under these conditions, if it is obtained perfectly fresh and kept in good condition, and if it is allowed to act for a period of twenty-four hours. It is specially valuable for the disinfection of drinking water because it does not affect the taste, does not alter the color, and in the proportion mentioned is perfectly innocuous. As regards cost, he calculates that sufficient drinking water—say 10 litres—for a family may be sterilised by means of H_2O_2 at a cost of about 5 cents per diem.

Selected Formulae.

ECZEMA.

Dr. Hardy considers internal treatment of the greatest importance in eczema after the acute stage is passed, and arsenic as the most important remedy. He gives the arseniate of soda in one-tenth of a grain dose, once daily. Dr. Brocq thinks internal treatment of importance in eczema, and prescribes in strumous cases cod-liver oil or a syrup containing iodine; in rheumatics, alkaline waters; in gouty subjects, colchicum, digitalis, etc. For eczema capitis the following local application is advised:

R	Napthol.	
	Camphor.	
	Resorcin	55 gr. x.
	Sulphur	5 j.
	Vaseline	5 j.

DIARRHŒA MIXTURE.

R	Tinct. opil.	
	Tinct. catechu comp.	
	Spir. camphors	55 part. aqu.
	Mix.	Dose.—30 drops in water after each evacuation.

If diarrhœa persists or increases, double the dose.

—Velpeau.

PILLS FOR DYSMENORRHŒA.

The following (*La Cronaca Medica*, September, 1891,) is recommended:

R	Camphor, in pulvere	5 grams. 5.
	Pulv. Doveri	gram. 1.
	Extr. hyoscyam.	5 grams. 5.
	Sufficient for ten pills.	One pill every hour until the pains disappear.

INUNCTIONS OF IODOFORM IN PULMONARY TUBERCULOSIS.

The following are two forms in which Flick employs iodoform by inunction in the treatment of pulmonary tuberculosis:

R	Iodoform	5 j.
	Ol. rose	5 j.
	Ol. anise	5 j.
	Ol. murrhu	5 j.
	M.	
R	Iodoform	5 j.
	Ol. rose	5 j.
	Ol. anise	5 j.
	Ol. olive	5 j.
	M.	

—News.

A SALVE FOR THE TREATMENT OF EXFOLIATIVE MARGINATE GLOSSITIS.

Dr. Besnier (*Le Bulletin Medical*, No. 9, 1892) recommends the following salve:

R	Hydrochlorate of cocaine	5 grams. 5.
	Balsam of Peru	55 gram. 1.
	Boric acid	5 grams. 5.
	Vaseline	30 grams. 30.

Apply locally twice a day.

INHALATIONS OF THE ESSENCE OF TURPENTINE IN FIBRINOUS PNEUMONIA.

Dr. G. Slepianin (*La Semaine Médicale*, No. 56, 1891) has found inhalations of turpentine of great service in fibrinous pneumonia. He uses the following mixture:

R	Essent. terebinthin	Glycerin pure	55 30 grams.
	Aq. destillat.		180 grams.

Sufficient for five or six inhalations.

This may be inhaled five or six times a day by means of a spray. Each inhalation should last five or six minutes, the patient lying quietly upon his side and breathing tranquilly; now and then let him take five or six long breaths. The writer found that the cases treated by this method ran a very mild course, while the patients were in a state of comparative ease.

DIARRHŒA MIXTURE.

R	Tinct. opil.	
	Tinct. rhel.	55 fl. s. s.
	Tinct. catechu co	55 fl. s. j.
	Ol. sassafras	55 fl. s. j.
	Tinct. lavand. co.	q. s. ad. fl. s. jiv.

Mix. Dose.—A fluidrachm after each movement.

—Loomis.

FOTHERGILL'S TONIC (CHARITY HOSPITAL.)

R	Sulph. quinine	16 grains.
	Sulph. strychnine	34 grain.
	Citrate potass.	30 grains.
	Tinct. chlor. iron	300 minims.
	Syrup.	1 fluid ounce.
	Water to make	55 4 fluid ounces.—M.

Dose, a teaspoonful.

LINIMENT FOR NEURALGIA.

Some eighteen years ago Mr. Thomas Edison, the wizard of Menlo Park, suffered terribly from neuralgia, and applied to his face, externally, the following neuralgia lotion. I made it for him several times, and, although I have not seen it used since.

R	Chloroform	5 fluid ounces.
	Sulphuric ether	1 fluid ounce.
	Alcohol	1 1/4 fluid ounces.
	Chloral hydrate	5 ounces.
	Camphor	1 ounce.
	Morphine sulph.	6 grains.
	Oil peppermint	1 fluid dram.

This, however, we do not think the druggist would be justified in supplying on a written request from a person unknown to him and without knowledge as to the method of use intended by the party sending the order.

—Editor *Pharmaceutical Record*.

THE PYLORIC PAIN OF DYSPEPTICS.

Dr. Coutaret (*La Semaine Médicale*, No. 8, 1892) recommends the following mixture as efficacious:—

R	Saturated chloroform water	55 gms. 500.
	Syrup of columbo	55 gms. 100.
	Extract of cannabis indica	55 gms. 10.

A teaspoonful every half hour until the pain ceases.

CYSTITIS.

Dr. A. W. Marsh (*Therap. Gazette*) recommends oxalic acid. His formula is as follows:

R Acid. Oxal.....gr. xvj.
Syr. arrant. cort.....℥ i.
M. Teaspoonful every four hours.

BALDNESS.

R Tinct. jaborandi.....3 iv.
Glycerin.....3 ij.
Lanolin.....3 ij.
Sig.: Rub a little into the scalp every evening.

—*Pharm. Era.*

TREATMENT OF PSORIASIS OF THE HEAD.

The following treatment is applicable only in cases of limited psoriasis and in the absence of all irritation of the scalp. It is recommended by Besnier and is as follows:—

1. The following ointment should be applied daily to the affected part:

R Sapo. viridis.....℥ 100 parts.
Vaselin.....10 parts.
Ichthyl.....10 parts.
Acid. salicylic.....℥ 5 parts.

M.

This should only be applied to small lesions on account of the high proportion of active ingredients.

2. Cease making applications as soon as any signs of irritation put in an appearance.

FORMULA FOR THE WINE OF COCA.

The following is recommended (*Pharmaceutische Post*, No. 27, 1891) as an excellent formula for the preparation of the wine of coca:

R Coca leaves.....℥ iij.
Cognac.....℥ iij.
Sherry wine.....Ojss.
Hungarian wine.....℥ vi.

Macerate for several days and add seven grains of citric acid. Allow this mixture to stand for several days and then filter.

SYSTEMIC INFECTION FROM GONORRHOEA.

At the late meeting of the Southern Surgical and Gynecological Association, Dr. Bedford Brown, of Alexandria, Va., read a paper on this subject. He cited five interesting cases of systemic infection from gonorrhoea. He believes that there are two channels for the absorption and transmission of the gonorrhoeal microbe into the general system. One is by continuity of surface over the mucous membrane of the genito-urinary tract from the urethra to the kid-

neys. The other channel is through the medium of the great lymphatic system, from the lymphatics of the urethra to the inguinal glands, thence through the lymphatics of the system into the general circulation. He believes also that this microbe, so transmitted, is lodged at different points in the organism. The gonorrhoeal microbe transmitted by continuity of surface over the genito-urinary tract, invariably induces specific suppurative inflammation. On the contrary, when transmitted through the lymphatics, the inflammation is not of a suppurative character, but assumes peculiar types; then the contact of the infectious microbe with the mucous surfaces produces suppurative prostatitis, cystitis, ureteritis, pyelitis, and then pyonephrosis. The absorption of the same through the lymphatic channels first sets up lymphangitis of the lymphatics of the urethra, then lymphadenitis of Cowper's glands, then of the inguinal glands, and inflammation of the connecting lymphatics. By further absorption it may induce septic phlebitis on the thigh, and finally synovitis, endocarditis, and internal destructive ophthalmitis. He also believes that, in certain cases, genuine septicæmia may be developed in the course of these complications. He thinks there is marked relative difference in the susceptibility of different constitutions to the systemic poisoning of gonorrhoeal infection, as in other diseases. That the absorption and infection of the system from this cause is only in exceptional cases. The writer lays stress on gonorrhoeal ureteritis following cystitis, as a part of the action of the gonorrhoeal infection in its travels over the mucous surface of the genito-urinary organs towards its fatal destination in this direction, the kidneys. This complication is accompanied with pain, at times sharp and paroxysmal, usually dull and aching in character. These sharp paroxysms of pain extend upward to the kidney, and not downward toward the bladder, as in nephritic colic. Then again, there is soreness in the entire line of the ureter, increased on pressure, so that the course of the canal may be marked out clearly. Ureteritis is always established before nephritis begins in gonorrhoeal infection.

The cases cited by Dr. Brown indicate that a state of pyæmia or septicæmia may be developed by systemic infection from gonorrhoea in certain cases.

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Leading Articles.

PENTAL AS AN ANÆSTHETIC IN SURGERY.

At the last meeting of the Society of German Naturalists and Scientists, held at Halle, Dr. Holländer demonstrated the value of pental as a dental anæsthetic. It was suggested that these short periods of anæsthesia might also be made use of in surgical procedures which occupy but a few moments.

The paper of Holländer stimulated Dr. V. von Rogner to test in the Royal Hospital of Wieden, in Vienna, the merits of pental in surgical practice. He used it principally in the public ambulance service, or in other words, in emergency cases, and his article has been ably discussed in the *Medicinische Neuigkeiten*. Before giving the results and comments on Rogner's work, a few words relative to the substance itself will be apropos.

It was in 1887 that von Mering resurrected the anæsthetic amylen. This substance, on account of its quintuple contents of carbon in its molecule, has been renamed Pental (C_5H_{10}). Pental is an extremely volatile fluid, having an odor somewhat similar to that of benzine. It is perfectly clear, limpid, of a cool, sweetish but ultimately of an astringent taste. Locally applied it is an irritant. It is inflammable, and burns with a yellow and very sooty flame. It is insoluble in water, but easily miscible with chloroform, ether and alcohol. It does not undergo any change if exposed to the light. Its specific gravity varies between 0.6788 and 0.6383 at a temperature of 36.8° C., and its boiling point varies between 35° and 38° C.

The preparation of the patient for pental anæsthesia is the same as for chloroform. For the administration of the anæsthetic, Rogner uses an Eschmarch's mask, the inner side of which is additionally furnished with a layer of cotton about the thickness of the finger. For each admin-

istration of the drug fresh cotton should be used in the mask. Pental, at present, can only be purchased in bottles containing 15 grammes, which constitute a single dose. The bottle should not be opened before immediate use and then the entire contents should be poured upon the mask. After the mask has been put over the patient's nose and mouth, the anaesthetizer's hand holding the mask, the mask and face of the patient should be covered with a compress to hinder the too rapid evaporation of the pental. The degree of anaesthesia can be determined as in the case of chloroform. The operation can be begun within 60 or 70 seconds after the application of the drug. Certain points regarding the successful administration of pental require some experience and dexterity to be obtained. In all cases, it is stated, anaesthesia supervened without any period of excitement whatever. In a majority of cases the conjunctival reflex is retained, but its presence, we are told, need not indicate that there is not sufficient anaesthesia. All unpleasant symptoms are absent and the anaesthesia occurs gradually and quietly. The pulse is apt to be rapid at first, but becomes regular and slow during the anaesthesia. There are, it is stated, no deleterious effects on the heart or respiration, nor were vomiting, headache or other untoward effects noticed. The return of consciousness usually begins in about four minutes, and then is rapid, although quiet. Even at this stage there is a considerable lack of sensibility, which will be found valuable during the application of dressings, bandages, etc. In all cases in seven minutes after the application of the mask the return to complete consciousness and well-being was complete.

Pental anaesthesia, while accompanied by a loss of sensibility to pain, is not always attended by entire absence of consciousness, especially in the first stages, although all will-power is entirely gone.

It is to be regretted that we have no data from the physiological laboratory to show just how this new substance acts upon the organism, and it is to be hoped that such will be obtained before much more of this injudicious experimentation on the human subject is pursued. The composition of pental is not such as would lead us to believe that it is one of the eminently dangerous anaesthetics, but these substances as a class demand the most thorough study of their physiological actions and the most solicitous care in their administration. One death has already been reported from its use.

ORAL DEFÆCATION.

Under the heading of "Collectanea Medica" our esteemed German contemporary, the *Deutsche Medicinal Zeitung*, occasionally interests its readers with a number of medical oddities, which frequently are of extraordinary interest. The issue before us tells us of a defæcation by the mouth, which was recently reported to the Paris Hospital Medical Society by D. Desnos.

The patient was an epileptic, who shortly after his admission to one of the Paris hospitals had an epileptic convulsion during which it was noticed that the bed linen was soiled by an ill-smelling fluid which in odor and color was like faeces. Upon being questioned the patient acknowledged that for the past two years he had been defæcating per os. He was watched and about six o'clock the same evening, an hour after his supper, the patient was seen to evacuate faecal masses through the mouth. In time it was noticed that this was his regular habit.

The abnormal mode of defæcation was accomplished in two different ways. At times the patient when feeling need would ask for a vessel, at once quietly and with only a slight vomiting effort evacuate the faecal masses. At other times the evacuations would be accompanied by a slight convulsion, during which the patient

would press his hand to his back in the region of the cesophagus, stating that he experienced a severe pain at this point.

The faecal masses evacuated would completely fill a spit-cup. They were formed, varying slightly in consistence on different days, and to all appearances had come from the large intestine after having undergone the digestive process of the small intestines. The odor was that of normal faeces, and not the fearful fetor of faecal vomiting occurring in cases of strangulation of the bowel. Upon examination they were found not to contain a vestige of nourishment, although evacuated one hour after the patient's meal time.

A few hours after defaecation the patient's abdomen would become tense, hard and somewhat enlarged, and he would point out a region of dullness in the lower portion of the abdomen which disappeared after the oral defaecation. The patient dates the cause of these extraordinary evacuations two years back, at which time he fell from a wall, striking upon a twig, which inflicted a perforated wound at the upper and inner part of the right iliac fossa. For a long time afterwards he experienced severe pain at this point. The only feasible explanation for the phenomenon seems to be that this wound established a communication between the large intestine and the upper portion of the small intestine.

Instances of oral defaecation have occasionally been reported as occurring in hysterical cases, but these may be explained by a spasmodic contraction of the large intestine, and only occurs occasionally and not habitually as in the case reported. It is doubtful if there is another case like this in medical literature.

A CORRECTION.

The Communication on Cephalhæmatoma With Report of Case in the issue of May 7th is by Dr. O. D. Walker, not by O. W. Wilson. The error occurred in making the type-written copy of the paper.

Book Reviews.

SURGICAL DISEASES OF THE OVARIES AND FALLOPIAN TUBES, INCLUDING TUBAL PREGNANCY. By J. Bland Sutton, F. R. C. S., Assist. Surgeon to the Middlesex Hospital, etc. 8vo., pp. 500, with 119 engravings and 5 colored plates. Philadelphia: Lea Bros. & Co., 1892.

This monograph will prove a welcome addition to the literature of diseases of women. The author's extensive studies of specimens of diseased ovaries and Fallopian tubes, together with his investigations in comparative anatomy and pathology make him specially well qualified to write a work of this kind. The present volume considers symptomatology and treatment as well as the pathology, but without doubt it will be prized chiefly as a contribution to pathology.

Part I. comprises 222 pages, and treats of diseases of the ovaries. Very little that is new is presented. The author elaborates a new theory concerning what have been called tubo-ovarian cysts. He differentiates a class which he styles ovarian hydrocele. The claim is made that it is only ovarian hydroceles which intermit, that is, which discharge at times their contents in the uterus—the *hydrups tubæ profluens* of the older authors. This theory being novel will require careful investigation.

Part II. contains 84 pages devoted to diseases of the Fallopian tubes. The author gives a most excellent exposition of the subject. It will be a pleasure to workers in this field to find the pathological facts involved presented to the profession in so temperate and convincing a manner. Gynæcologists have had hard work to convince the profession of the facts concerning diseases of the tubes, but when pathologists are convinced, as in the case of the author, the fruition of their labors is at hand.

Part III treats of tubal pregnancy, and embraces 121 pages. The author is in close agreement with Tait, both in pathology and treatment. Hæmatocele is considered as being due to ruptured ectopic gestation almost without exception. The treatment advised is abdominal section.

Part IV treats of the methods of performing operations for ovarian and tubal diseases. This section could have been omitted with advantage, as it is too con-

cise to be of special value, and adds nothing to the book.

The illustrations are unusually good, many of them being new, and the letterpress is that characteristic of the Leas.

We can recommend this book to every one interested in the pathology of the diseases of women, and believe that it really fills a "long felt want."

TRANSACTIONS OF THE AMERICAN ORTHOPEDIC ASSOCIATION. Fifth session, held at Washington, D. C. Sept. 22, 23, 24, and 25, 1891. Volume IV. Philadelphia: Published by the Association.

This volume is made up of over 400 pages, embodying lists of the officers, presidents; members, and corresponding and honorary members; minutes of the Third Annual Meeting; the Constitution and By-Laws; and 54 papers on various topics in this specialty. There are also many illustrations and discussions.

The work is highly creditable to the Association, and we regret that want of space renders it impossible to review the many valuable contributions which it contains,

TRANSACTIONS OF THE NEW YORK STATE MEDICAL ASSOCIATION FOR THE YEAR 1891. Volume VIII. Edited for the Association by E. D. Ferguson, M. D. New York City: Published by the Association, 64 Madison Avenue.

The Association is to be congratulated upon the amount and character of the work contained in the nearly 700 pages which constitute this last volume of their Transactions.

WARNER'S THERAPEUTIC REFERENCE BOOK. Philadelphia: William R. Warner & Co. 1892.

This little book, which has reached its fourth year of publication, is of a convenient pocket size and contains much matter of value to the practising physician. We find articles such as, aid in memorizing doses, treatment of asphyxia, time of incubation of eruptive fevers, digestibility of foods, pharmaceutical formulæ, medical formulary, periods of gestation, hypodermic medication, incompatibles, parvules, pills, poisons and antidotes, posogoloical table, prescription writing, and weights and measures.

Periscope.

THERAPEUTICS.

THE TREATMENT OF SYPHILITIC SUBJECTS WHO ARE PREDISPOSED TO DISEASES OF THE NERVOUS SYSTEM.

In the *Gazette hebdomadaire de Médecine et Chirurgie*, 1891, No. 51, p. 606, appear the essential facts of a paper by Dr. Alfred Fournier, which was presented before the French Society of Dermatology and Syphilography. Taking up the question of the possibility of mercury being the cause of tabes in syphilitics, he disposes of this question by citing indisputable facts which show the impossibility that this can be the case, believing that those are predisposed to syphilis of the nervous system who suffer from nervous exhaustion (intellectual, moral or physical), and who are of a nervous heredity. He suggests the bromides to subdue nervous excitability, and hydro-therapy as a preventive. In the actual treatment by mercury and the iodides, in cerebral syphilis, some brilliant results; in medullary syphilis, failures in greater number than successes; in tabes, in early stage, complete cure—later, eventual possibility of cure or holding the disease in check; if ataxia is confirmed, absolute powerlessness; finally, in general paralysis, in his experience, failure. He believes that greater success will be obtained in the prevention than in the cure of nervous diseases of syphilitic origin.

SULPHATE OF CINCHONIDINE IN THE TREATMENT OF VARIOUS TYPES OF MALARIAL POISONING.

In the *Bulletin Général de Thérapeutique* for December 30, 1891, there appears a paper on the above subject, the author being Gemayel.

After detailing a number of cases in which he employed this alkaloid of cinchona in preference to quinine, he reaches the conclusion that cinchonidine is equal in rapidity of action and efficiency to quinine, if not superior to it, producing in all the cases to which he has given it brilliant results. He has found it particularly useful and advantageous in those fevers which have resisted quinine. Neither does he believe it to have the contra-

indications which often exist against the use of the older alkaloids. He orders one and a half drachms of sulphate of cinchonidine, divided into four powders, and that one of these shall be taken the first, second, fourth, and the sixth day. On the third and fifth day the treatment is suspended. In the course of the following week the same treatment is repeated. By this means he endeavors to prevent a return of the disease, which, of course, is very important. The time which is best for the administration of the drug is just before going to bed. In this way the inconvenience of buzzing in the ears or other disagreeable symptoms, such as nausea, are escaped. However, if the attacks are severe, it is well to give the cinchonidine at other times. It is hardly necessary to add that arsenic, iron and hydrotherapy are useful adjuncts to cinchonidine in the treatment of chronic malaria.

THIOL IN SKIN DISEASES

Buzzi's (*Charité Annalen*, 1891, Band xv.) experiments in Professor Schwengeler's clinic in Berlin lead him to regard thiol as superior to ichthyol. It is valuable in many diseases of the skin, and possesses the following advantages over ichthyol: it is clean and never irritates, whereas ichthyol is impure and often irritates; ichthyol smells disagreeably, thiol does not; ichthyol spots the linen, thiol does not. It moreover has the advantage of costing only one-half as much as ichthyol.

INJECTIONS OF INFUSION OF NERVOUS TISSUE IN NEURASTHENIA.

Const. Paul (*Bull. de l' Acad. de Méd.*, No. 7, February 16th, 1892) describes the effects of injections of a glycerine extract of the grey matter of sheep's brain. His experiments were continued for more than a year. The material employed was made by macerating the grey matter of sheep's brain for twenty-four hours in five times its weight of glycerine, afterwards diluting with an equal quantity of water and filtering through porcelain under great pressure. With this material, injections (from 2 to 5 c. c.) are made into the loose cellular tissue of the dorso-lumbar region. They were perfectly well borne, and gave rise to practically no inconvenience. De-

tailed reports of eleven cases are given. They may be classified as follows: 3 of chloro-anæmia with neurasthenia, 3 of simple neurasthenia, 1 of abnormally slow pulse, 4 of ataxy or tabes. M. Paul's conclusions are as follows: The patients feel first increased strength and improved spirits; the amyosthenia and muscular impotence diminish rapidly, exercise being taken without fatigue; pains in the back and spinal hyperæsthesia disappear after a few injections; even in ataxy the "lightning pains" cease; neurasthenic headache and insomnia also vanish, and there is increased cerebral activity. The patients feel their appetite improved, gain in weight, and lose any symptoms of dyspepsia which may have been present. In the case of chlorosis the use of iron was with advantage combined with the injections. The author thinks that in the new treatment we have a true "neurosthenic" tonic—to borrow an expression of Trouseau. In neurasthenia, although the patient may eat well, he is incapable of converting his food into force which can be employed as desired. The injection of nervous tissue allows of this utilization of food and of its being stored up in the form of potential force. In the cases quoted nervous force is developed first, allowing greater mental activity. Increase in weight and enrichment of the blood follow later but none the less surely. The author has recently commenced observations on a saline extract of grey matter in place of the glycerine extract above mentioned, but the results are not ripe for publication.—*Brit. Med. Jour.*

TRIONAL AND TERTONAL IN MENTAL DISEASES.

Kast and Baumann, in their work upon the relationship between the chemical constitution and physiological action of certain sulphones, concluded that the hypnotic energy of these bodies would be increased in proportion to the number of contained ethyl groups; thus trional (diethylsulphon-methylethylmethane) would be more active than sulphonal (diethylsulphon-dimethylmethane), and tertonal would be more powerful than either of the preceding. Barth and Rumpel tested the point, and failed to discover that the new compounds were superior to sulphonal. Schultze (*Therap. Monats.*, October, 1891)

has investigated the action of the former bodies in various forms of insanity. In maniacal conditions tetronal was always less efficient than trional, and the latter failed to cause sleep in many cases, even when the dose amounted 3 or 4 g. Restlessness was diminished by this dose. Better results were obtained by administering 2 g. night and morning. Excitement and destructive propensities were much lessened by this method; 1 g. of trional each morning was found to act well in subduing the excitement of very demented or imbecile patients. In several paranoiacs who were tortured throughout the night by their hallucinations, 1 to 3 g. of trional proved an efficient soporific. The hallucinations of one of these patients were aggravated by 2 g. of tetronal; emesis, cephalalgia, and loss of appetite were also induced. In all these cases tetronal was inferior to trional. Schultze concludes that trional is a more reliable sleep producer than sulphonal or tetronal, and very rarely gives rise to unpleasant after-effects. He estimates that in uncomplicated insomnia trional will succeed in 75 per cent. of cases and tetronal in 60 per cent.—*Brit. Med. Jour.*

EXTRACT OF MALE FERN.

The physiological properties of the ethereal extract of male fern have recently been investigated by M.M. Prevost and Binet, of the University of Geneva, who find that grave results seldom follow even large doses introduced into the stomach of man and warm-blooded animals, in consequence of the slowness with which the drug is absorbed, but that hypodermic, and, still more, intra-peritoneal injections, kill animals by paralyzing the heart and respiration. The most prominent symptoms are paralysis and early rigidity of the voluntary and involuntary muscles, preceded by vomiting, dyspnoea, shivering, and cold. The chief cause of death is paralysis of the heart, which is found immediately afterwards firmly contracted in systole, and incapable of responding to stimuli. The vagus does not lose its inhibitory power until just before death. A great loss of vermiform movements is observed in the intestine in the case of the rabbit, the rat, the guinea-pig, and the pigeon. When the drug is applied to the conjunctiva the sensibility of the cornea is diminished, and

subsequently arrested without any change being observed in the pupil. In cold-blooded animals the central nervous system is quickly paralyzed. There would seem to be a special action on the protoplasm which causes the muscular and other changes observed.

THE TREATMENT OF ACUTE CROUP- OUS PNEUMONIA.

Dr. Marcel Boudouin, under the direction of *La Semaine Médicale*, has ascertained the various methods of treatment of this disease which are in common use in the hospitals of Paris (*Ibid.*, pp. 222, 223). M. Cornil, seeming to regret that venesection is obsolete, at the outset directs wet cupping, blistering, alcoholic stimulation; and Dover's powder to favor perspiration. M. Dujardin-Beaumetz uses caffeine in preference to alcohol, recommending also kola; for nervous manifestations, chloral, or, in alcoholic subjects, paraldehyde, blistering only when the signs are persistent. M. Peters treats his pneumonias according to their condition: wet cups in early cases, tartrate of ammonium frequently, but according as they are robust, debilitated (with alcohol), or bilious. M. Bucquoy believes in bleeding and tartar emetic, sulphate of quinine, and blisters. M. Rigal has practised intra-pulmonary injections of antiseptic substances (sublimite, etc.), also administers sulphate of quinine and uses cold baths. M. Moizard, in adynamic forms, injects ether or caffeine, and even sparteine. M. Oulmont uses these remedies with small doses of digitalis. M. Huchard uses ether, camphor, or digitalis, and avoids all depressing remedies, as antimony.

THE SULPHATE OF DUBOISIA IN MENTAL DISEASES.

Preiniger has used the sulphate of duboisia as a culmative and hypnotic in mental affections with good results. The action of this agent much resembles that of hyoscine, while its inconveniences, when given in too strong a dose are the same. When administered to an insane patient, sleep sets in, in from ten to twenty minutes, and lasts from one to eight hours. Sometimes the sleep is of short duration, yet, on awakening there persists a somnolent condition and prostration which more or

less takes its place. If the dose be larger than two and a half to three mgrms., the patients become agitated, the extremities jerk, the pulse becomes accelerated, the respiration increases in frequency, and the temperature rises—even hallucinations may set in. The peculiar idiosyncrasies of patients with regard to occustecination and its intensity of action should be borne in mind. The maximum dose for subcutaneous use, and which should not be increased, is two mgrms.—Administered by the mouth it sometimes does not act.—*Le Bulletin Médical*, No. 88, 1891.

THE TREATMENT OF CYSTITIS.

In an article upon cystitis in the *Atlanta Med. and Sur. Jour.*, March, 1892, Dr. Murphey, of Atlanta, writes:—In the treatment of cystitis, the measure of the first and greatest importance is absolute rest. The rest should be in bed, with hips slightly raised, in order that pressure may be taken off the neck of the bladder. Constitutional treatment consists in regulating the character of the urine, so that it shall be unirritating to the diseased bladder.

To render the urine less irritating give alkaline diuretics, demulcent drinks, etc. Citrate of potash is one of the most valuable alkaline diuretics and is often advantageously combined with buchu, uva ursi, triticum repens.

Opium should be used to allay pain, lessen excitability and relieve spasmodic action. I usually prefer suppositories of opium and belladonna, but if the spasm alone is causing the pain belladonna alone will relieve it, which is preferable. Poul-tices over the hypogastrium and perineum or hip-baths are useful. The bowels should be kept regular and free in order to secure free action of the portal circulation and prevent straining at stool. Free action of the skin and bowels relieves the taxed kidneys and bladder, giving them less to do. Saline purgatives are better suited for this purpose. Sulphate of magnesia or a glass of a laxative mineral water before breakfast usually acts nicely. Digestion should be watched with care; in fact, I have found cases that could not be relieved until the state of the digestion was improved.

The diet is an important factor that

should not be overlooked; irritating articles of food should not be allowed, spirits, alcohol in all forms must not be allowed; coffee and tea should not be allowed. Nothing should be taken that disagrees in the least with digestion.

In a mild case of cystitis, I do not adhere strictly to all of the rules laid down here, but let the patient continue at business if desired, and by proper care and treatment he may be relieved in a short time. For example, the urine is too acid or too alkaline; acts sometimes like a foreign body; it irritates, and the bladder will make efforts to expel it. Deposits of any urinary solids in the viscus are likely to produce an irritable condition. Such cases being of a mild form can readily be relieved if not allowed to stand too long.

In advanced stages of cystitis local treatment can be employed advantageously, by washing out the bladder carefully with medicated injections.

MEDICINE.

ATAXIC PARAMYOTONIA.

Gowers (*Centralbl. f. Nervenheilk. u. Psychiatrie*, February, 1892, p. 41) has reported the case of a man forty-one years old, with a history of syphilis of eleven years' standing, in whom for a year and a half an abnormal tonic condition of the muscles, first in the lower, then in the upper extremities, had existed. The patient was well nourished; the extremities were large and the muscles well developed and hard. This hardness was dependent upon tonic spasm that interfered with voluntary movement, rendering it slow and difficult. There was no special rigidity; extensors and flexors were apparently involved in like degree. The spasm was not diminished by repetition of movement, but was constant and opposed passive as well as active movement. There was at the same time some muscular weakness. In the upper extremities coördination was impaired. The muscle-sense was defective, especially as to posture, size and weight. The electric irritability of the muscles was preserved. It was not possible to elicit the knee-jerk or other evidence of myotatic irritability, although the failure may have been dependent upon spasm. Tactile sensibility was lost upon

the palms of the hands, diminished on the dorsal aspect of the terminal phalanges, and on the soles of the feet. There was often a sensation as of standing upon a circular base. The sense of pain was retarded upon the palms of the hands. The temperature-sense was almost normal. There was almost complete impotence. The action of the sphincters were preserved. There was an absence of pain and of cerebral derangement. Gowers considers the affection as analogous to Thomsen's disease and dependent upon functional derangement of the gray matter of the cord, as a result of which there is increased activity of the motor nerve-cells that control normal muscular tone.—*Amer. Jour. Med. Sci.*

THOMSEN'S DISEASE.

Dr. C. L. Dana showed at a recent meeting of the New York Neurological Society a man thirty-three years of age presenting the typical phenomena of this disease. The family and personal history of the patient were good. At the age of seventeen weakness of the muscles was first noticed, and three years later the patient found that after clenching the fists he was unable to open them. The affection had gradually become greater and more extensive, until the only muscles not involved were those of the thighs and upper arms. The myotonia was most marked in the forearm and leg muscles, the tendon reflexes were only obtained with difficulty, and there was no sensory disturbance. The reaction to galvanism was slightly increased, that to faradism normal. Dr. Dana expressed the opinion that the phenomena were confined to the muscles, and that the disease was a purely muscular one.—*Lancet*.

HEREDITARY TREMOR.

Debove, *Gaz. des Hop.* 99. 1891. (Abstract by Möbius, in *Schmidt's Jahrb.*) Charcot has lately described a hereditary form of tremor which had been previously mentioned by Fernet. Debove reports the histories of two families thus affected, in one of which it had gone through five generations. His conclusions are as follows: There is a hereditary tremor which may be transmitted in either sex, beginning in

childhood and increasing in advancing years. Its rhythm is about eight or nine to the second and it disappears when the muscles are completely at rest. The outstretched hand trembles, but voluntary movements do not increase it. It may involve the limbs, the eye-lids, the lips, or the tongue, but the hand is the most affected. The fingers do not have an independent tremor. The author adds that further observations may confirm or modify his views. Prof. Möbius calls attention, in his notice of Debove's article, to the fact, that in his "Diagnostik" he had described a tremor essentialis which agreed in its symptoms and in its hereditary character with the above, but with this difference, that in his cases the tremor first appeared in mature individuals, or in those of advanced age.

ETIOLOGY OF ITCHING.

According to Dr. E. B. Bronson (*Medical Record*, Oct. 24, 1891), the primary cause of itching pertains to hidden molecular or dynamic changes within the sensory nervous apparatus, changes whose immediate effect has been presumed to be of the nature of a dysesthesia, and whose only ostensible sign is the perturbed sensation. The accessory pathological causes he tabulates as follows: Predisposing causes.—A: A state of cutaneous hyperæsthesia, or excessive irritability of the cutaneous nerves. It may occur, (a) as the local expression of a general neurotic condition, congenital or acquired, in which case the simplest excitants, as friction of clothing, may evoke the sensation; or, (b) it may be due to local changes in the skin, attended with prolonged irritation of the cutaneous sensory nerves. B: A state of hypopselaphesia, i. e., a state of impaired conduction in the cutaneous nerves of tactile sense. Though usually occurring as a concomitant of hyperæsthesia of the skin, it is possible that it may exist independently of the latter, as in atrophic conditions (more particularly in pruritus senilis), when, like hyperæsthesia, it may become the predisposing cause of itching. Exciting causes.—A: Irritations conveyed to the skin from the interior of the body, either as (a) reflex irritations; or as (b) irritations transmitted from nervous centres. B: Direct or local irritation, (a) from extraneous sources, i. e., from such

irritants as operate upon the surface of the skin; (b) from intra-cutaneous sources, comprising (1) lesions of trophic cutaneous diseases and their products; (2) toxic materials deposited from the blood; (3) effects of local nutritive disturbances, or deranged metabolism in the cutaneous sensory nerves; (4) spastic contraction of the arrectores pilorum muscles, which, though it may not of itself suffice to cause itching, is probably often associated with other causes as a contributory factor.

FIBRO-SARCOMATOSIS.

Dr. Langenbuch recently presented at the Freie Verein der Chir., in Berlin, a patient who had had several months before about eighty fibro-sarcomata scattered over the skin's surface. An energetic treatment with iodides and arsenic had already resulted in a decrease in the tumors, when an erysipelas suddenly developed and spread over the entire surface. The consequence of this was that, within the space of five days all the sarcomata had disappeared and the skin had become normal. After the space of a year a slight recurrence had taken place, and a tumor the size of a plum was to be seen in the region of the neck.

GENERAL ATHETOSIS.

Dr. Hugh Hagan reports a patient, aged four years, who was of normal birth and healthy extraction. Was healthy up to nine months of age. Taken ill on Friday and until the following week had continued convulsive attacks marked by high temperature. Fever lasted five weeks. During convalescence the mother noticed "the child moved constantly in all its joints." Author says the child was brought to him two years after first illness. Patient is in a state of constant motion. Movements are marked by that apparent volition and rhythm so different from the jerky, spasmodic character of the choreic. The eyes, though in a more or less constant state of movement, do not present the rapid vibratory character of a true nystagmus, but are more slowly and irregularly drawn up, down, in or out, as a result of the spasms of the internal ocular muscles. The masseters and temporals close the lower jaw so as to lacerate the tongue, which is alternately protuded and retracted. At

times marked opisthotonos. Cannot sit or stand unassisted. Totally ataxic aphasic, but, so far as his education will permit, probably not amnesic. The athetoid movements cease entirely during sleep. When at rest the parts assume their normal physiological positions, no evidence of contracture or contraction being present. He thinks that the condition present is due either to a cerebral tumor, or to meningeal adhesions over the motor cortical region, and sees no reason why this condition could not produce the symptoms as well as those generally found.—*New York Med. Jour.*, Jan. 16, 1891.

HISTOLOGICAL ALTERATIONS OF THE NERVOUS CENTRES PRODUCED BY ELECTRICAL SHOCK.

Magini, of Rome, experimented upon dogs, cats, pigeons, white mice and rabbits, employing the potential electrical apparatus of Winsurth. After examining the brain cord and peripheral nerve carefully he arrived at the following conclusions:

1. That death by electrical shock, where there is no external or appreciable internal lesion, is produced by a profound alteration taking place in the ganglion cells of the cerebro-spinal system.
2. That such ganglion cells show great changes in size, being shrivelled and atrophied, deprived of nucleus and nucleolus, and accept an intense stain.
3. That the electrical shock, oft repeated, favors diapedesis.

"GONORRHOEAL CYSTITIS."

Du Mesnil (*Virchow's Archiv*, vol. cxxvi, 1891, Part III) denies that there is such a thing as specific gonorrhoeal cystitis. When gonococci are found in the urine, they have, in all probability, entered with urethral pus, and are not new products developed from the true specific inflammation of the vesical mucous membrane itself. In women pus from the urethra or vagina might easily get into the bladder in this manner. Du Mesnil maintains, on the strength of fresh researches, that gonococci cannot alter the composition of the urine, and that cystitis with ammoniacal urine is not produced by these germs. Indeed, the urine renders the gonococci harmless or kills them entirely.—*Brit. Med. Jour.*

GLYCOSURIA AND LOCOMOTOR ATAXIA.

Guinon and Souques call attention to the fact (*Arch. de Neurologie*, Nov., 1891,) that tabes may have crises in which sugar is found in the urine, and that in the family of ataxics may be found glycosurics. DeWolf points out (*American Lancet*, Vol. VII.) that during the parietic apoplectiform attacks, and after locomotor ataxia gastric crises, glycosuria may occur. Kiernan states (*American Lancet*, March, 1884,) that glycosuria may be present in the urine of parietic dementals after both epileptiform and apoplectiform attacks.

LEPROSY.

Looft (*Centralbl. f. d. Med. Wiss.*, 1891, p. 764) has found bacilli in anæsthetic spots in four cases of pure anæsthetic leprosy, the cases representing four stages of the malady from two to seven years' duration. The portions of skin examined were excised from the periphery of the spots. In the sections from the old patches the bacilli were very few in number. In no case were bacilli found in the muscles in which the fibrillæ had undergone fatty degeneration.—*British Med. Jour.*

SURGERY.

OUTSTANDING EARS.

Mr. William Thomas, of Birmingham, describes, in the *British Medical Journal* for October 17, 1891, the following operation by which he has succeeded in making flaring ears lie close to the head. The operation consists in the removal from the inner surface of the pinna of an elliptical piece of skin, dividing the cartilage of the pinna down the center of the exposed cartilaginous surface, and uniting the margins of skin by sutures. The widest part of the skin removed should be from one-half to three-quarters of an inch, but of course this depends on the degree of deformity. It is necessary to divide and turn back the cartilage, not only to remedy the deformity, but also to allow of easy approximation of the skin margins, and care must be taken to avoid division of the outer skin with the cartilage. The after treatment consists in the application of a small cotton-wool pad between the head and the pinna—the latter being fixed by a

bandage until healing is complete. Immediate union takes place, and there is hardly any perceptible scar, the skin of the ear having great vitality. A simple method of keeping the outstanding ears back without operation is to fix them by a piece of lint soaked in collodion, and placed between the pinna and the head, the ears being bandaged close to the head until the collodion is firmly set. The adherent splint thus formed will hold the ear in position for two or three weeks, when it may be renewed. It is, however, only a temporary measure. The principles of the operation are applicable to various malformations of the pinna.—*St. Louis Med. and Surg. Journal*, January, 1892.

PENTAL IN SURGICAL PRACTICE.

V. v. Rogner (*Wiener med. Presse*, 1891, No. 51) used pental very successfully in cases where narcosis is required for a short time only. The same conditions for its use obtain as for anæsthesia from chloroform.

He used Esmarch's inhaler, covered on its inner side by a layer of wadding.

Narcosis in sixty or seventy seconds, in all cases, followed its administration, without any stage of excitement and without any injurious effect upon the heart or respiration.

At the expiration of three minutes the patient awakes quickly and quietly, but anæsthesia lasts for several minutes more.

INTRA-CRANIAL SURGERY IN ITALY.

It is cheering to witness the advance of surgery in Italy, which now bids fair to resuscitate the best traditions of Fallopio, Tagliacozzi, and Scarpa. Intra-thoracic and intra-abdominal surgery owe not a little to her recent operators, prominent among whom may be mentioned poor Count Loreta of Bologna, whose tragic end on July 23rd, 1889, as described in *The Lancet* of August 3rd following, is one of the saddest pages in the annals of the profession. His resection of the liver, and, still more, his digital division of the œsophageal and pyloric orifices of the stomach, did not require the commemorative tablets in the Bologna Hospital and University to perpetuate their author's pre-eminence among his contemporaries.

His influence and teaching are still active for good in the direction which would have pleased him most—that of intracranial surgery. In Florence, the week ending March 12th has been signalised by a brilliantly successful operation in this department. Professor Baiardi, of the Spedale della Maternità there, had under his charge in the children's ward a little boy of four years and two months, suffering from "general cortical epilepsy," according to the official bulletin, "and idiocy." Having trepanned the cranium, Professor Bairdi (assisted by Drs. Mattacci and Giarre) removed two great tracts of bone in the parietal regions, "in correspondence with the *zona matrix* of the cerebellum." From the first day after the operation the little patient's eye, nearly always wandering, uncertain, and unconscious, "si mostrò sereno ed animato da un lampo di intelligenza" (showed itself serene and enlivened by a flash of intelligence,) the "habitual restlessness was replaced by calm," and "sleep came to restore the feeble limbs of the child, which, a prey to sickness at the threshold of life, had neither consciousness nor instinct, could neither speak, nor walk, nor indicate its bodily requirements in any way; did not even know how to masticate." The recovery, vigilantly watched and assisted, is already so far satisfactory as to warrant every confidence in the lasting success of Professor Baiardi's operation.—*Lancet*.

A NEW OPERATION FOR CONGENITAL PTOSIS.

Gillet de Grandmont (*Rec. d'ophtal.*, April, 1891) describes his operation as follows: (1) After having seized the upper lid with a Snellen's forceps, the skin is cut through parallel to the free border of the lid, the incision being three or four millimetres from the border and about two centimetres and a half long. (2) Raise up the two cutaneous flaps and detach and excise the corresponding portion of the orbicular muscle, so as to expose the entire tarsus from the ciliary border to and including Sappey's orbito-palpebral muscle or tendon of the levator palpebræ. (3) Cut through the entire thickness of the tarsus, for an extent of two centimetres, parallel to the free border of the lid, and from two to four millimetres from it. (4)

Describe a curvilinear incision, with cavity downward, extending from one end of the first incision of the tarsus to the other. This incision should extend through all the tissues of the lid, including the conjunctiva. (5) The upper or orbito-palpebral flap should then be stitched to the lower or tarsal flap by three sutures without touching the skin.

SURGICAL TREATMENT OF GRANULAR CONJUNCTIVITIS.

For those cases of granular lids which are not benefited by the ordinary antiseptic caustic treatment, the following method is recommended by Darien, (*Archives d'Ophthalmologie*), and has been successfully carried out for more than a year.

All the cases, numbering 130, were much improved, and the great majority quite cured.

The patient being anaesthetised, the lids are thoroughly everted and the palpebral fissure split, if necessary. Every granulation is incised and then scraped out with a small sharp spoon. The lids are thoroughly scrubbed with a brush of short, hard bristles, and a 1:500 sublimate solution is well rubbed in with absorbent wool.

Iced compresses are applied for the first day. The lids must be everted, any adhesions separated, and the eyes bathed with a strong sublimate lotion every day. In about a fortnight the conjunctiva will be smooth and healed, but the patient must be kept under observation for a month longer to guard against a relapse.

SILKWORM-GUT IN SURGERY.

Bianchi (*Reforma med.*, 1891, May 1) says; Silkworm-gut, *crin de Florence* of the French, is not the bowel of the silkworm, but the worm's silk producing gland with its contents. To render the material aseptic, Bianchi places it in a 5-100 solution of carbolic acid, then boils it for one hour in a 3-100 solution of boric acid, and preserves it in a 1-1000 solution of sublimate. He has used the gut very extensively and claims it to be preferable to silk and catgut, as it does not absorb the secretions, and is suitable for plastic operations as well as for suturing of nerves and bones. A thread eighteen to twenty cms. long can sustain twenty to twenty-three kilograms. Bianchi used the silk-

worm-gut in the following operations among others: In two resections of the knee, two osteo-plastic operations by Pirgoff's method. One Ogston's astragalo-navicular resection, one fracture of the patella, per valgus, and in compound fracture of the bones of the forearm and the humerus, etc.

RADICAL TREATMENT OF NASAL POLYPI.

Casselberry (*N. Y. Med. Jour.*, Nov. 14th, 1891), in order to gain access to myxomatous polypi in the nose, recommends the reduction of hypertrophied turbinated structures by the electro-cautery; the removal of septal excrescencies by the saw, chisel, or drill; and the correction of septal deflections. For removal of polypi he recommends the snare, supplemented by occasional use of the forceps. After removal of the growths, the so-called roots are to be thoroughly cauterized by means of the galvanic cautery. A fine electrode, slightly curved, may be insinuated beneath the middle turbinated body to the region of the hiatus semilunaris, from the edges of which polypi are known to spring very frequently. By these means the majority of cases can be permanently cured. Nevertheless, there are certain cases which Casselberry maintains can only be cured by removal of the antero-inferior and of the middle turbinated body. These are the cases where, owing to narrowness of the superior nasal zone, or enlargement or malformation of the middle turbinated body, there is an impediment to proper access to the diseased parts, and the space is insufficient to insert an electrode to the region of the hiatus semilunaris. He considers properly constructed turbinated bone scissors the easiest and best means of removal in most cases. Where, however, there is not space on each side of the body to permit the passage of the blades sufficiently high up, he uses a wire snare *écra-seur* for removal of the part.—*Brit. Med. Jour.*

FISSURA ANI.

In a paper which recently appeared in the *Southern Medical Record*, Dr. Willis F. Westmoreland, says: I wish to speak now with reference to operations for fissure in ano. A great many physicians recommended the use of speculums for stretch-

ing the muscle; while other operators advise you to take a knife and nick the muscle before you stretch it. In olden times surgeons introduced their hands into the rectum, closed their fist and then pulled it out, stretching the muscle in that way. In the use of these different methods you cannot tell how far you stretch the muscle. I have never seen patients lose control of the sphincter as a result of this operation where the fingers or thumb had been used as a method of operation. Incontinence of the feces occurs in those cases where the muscle has been cut, stretched with speculum, or where some of the old methods have been used. My plan is to put the patient under the influence of an anæsthetic. I stretch the sphincter; I feel the contracted parts of it have given way while my patient is under the influence of an anæsthetic; take my finger out, and then if there is not any contraction of the muscle—none at all—I let it alone. If the sphincter contracts, it shows that the contracted part is not thoroughly broken up, and I stretch it more while the patient is still under the influence of the anæsthetic.

A CASE OF DEPRESSED FRACTURE ON THE LEFT SIDE OF THE SKULL, WITH SYMPTOMS; TREPHINING; RECOVERY.

Cheyne, (*Lancet*, 1891, ii., 813.) gives the following history: F. V., a boy aged four years, was brought to the hospital on August 23, 1888. Three days previously he fell from a balcony fifteen feet high, on to a stone floor. When picked up he was unconscious and severely bruised about the left side of the head; and there was a lacerated wound above the left eyebrow. He regained consciousness in about seven minutes, complained of severe pain in the head and soon became very sick. The sickness and vomiting continued until the day before admission, and was accompanied by restlessness, fever and pain in the head. On the morning of admission he seemed duller, and there was twitching of the eyes and hands. The boy seemed dull and stupid. The right eye was widely open, and the left upper lid slightly drooping. The right pupil was dilated and reacted imperfectly to light; the left was normal in size and reaction. There were no signs of facial or other paralysis. While he was in the out-pa-

tient room distinct twitching came on in the left side of the body; the face, hand and arm being more affected than the leg. At intervals this spread to the right arm and leg. This condition continued until the operation (two-and-a-half hours later), the twitching at times being very severe, and during the whole of this time the boy was quite unconscious.

On examination there was found a depressed fracture of the frontal bone, just above the outer side of the left orbital process, from which a fissure ran vertically upwards for an inch and a half. Trephining was done and the depressed bone elevated or removed. After the operation the boy slept well and was quite conscious on awakening. There was no recurrence of the twitching, but the left arm and leg were paralyzed as regards motion. This paralysis passed off entirely in a few days, and the boy made a rapid recovery.

OBSTETRICS.

RUPTURE OF THE UTERUS AT THE BEGINNING OF LABOR.

Cercha (Przeglad Lekarski, abstract in *Repertoire Universel d'Obstetrique*, 1892) reports the following case: 4-para at term. Suddenly on March 1st, great pain on right side of abdomen, low down. The pain soon disappeared. On examination the cervical canal was slightly patulous; the head movable above the pelvic entrance, the membranes intact. For three days there was no more pain; on the fourth day, repeated chills, fever, meteorismus, restlessness, collapse. There was œdema of the vulva. The distention of the abdomen was so great that one could distinguish nothing in it. The foetal heart sounds could not be heard. On internal examination hydrocephalus of the foetus was discovered. At first an attempt was made to perforate the head, but on account of its free motion this could not be done. [Why not fix with vulsellum?] Podalic version was then tried, but did not succeed. Finally the os was dilated with hydrostatic pressure sufficient to allow full access to the head, when perforation was done, and a one-half litre of fluid ran out. It was impossible to extract without a cranioclast, for the cranial bones were disarticulated, so podalic version was done. In

endeavoring to extract the placenta it was found in the abdominal cavity, having escaped through a rent in the right wall of the uterus; there was considerable hæmorrhage. No injection was given. The wound was tamponed with iodoform gauze, after replacing the prolapsed intestines. The woman recovered, but had fever for six weeks. There remained a small vesicovaginal fistula. The author quotes the similar cases of Hoffman and Simson.—*Univ. Med. Mag.*

LARGE HÆMATOMA AFTER LABOR.

C. Braun (*Centralbl. f. Gynäk.*, No. 10, 1892) exhibited before the Vienna Obstetrical Society last February a case in which an enormous hæmatoma developed on the third day after labor. The patient was a 3-para, aged 26. She was admitted into hospital twenty-five hours after rupture of the membranes. Then decapitation was necessary, as the presentation was transverse and had been mismanaged. The head was delivered with forceps. The cervix and vagina were plugged on account of laceration of the cervix and vestibule, which could not be controlled by ligature. In three days the hæmatoma developed; it arose in the left broad ligament, and extended upwards nearly as far as the right hypochondrium. The temperature was then normal, the pulse rose to 130, and the respiration to 60. The patient was kept in bed and ice bags were applied to the abdomen. Sixteen days later the hæmatoma and general symptoms appeared unaltered. After that date recovery was rapid, and when the case was exhibited no trace of the disease remained save a small, irregular, resistant mass in the neighborhood of the iliac fossa, quite free from tenderness.—*Brit. Med. Jour.*

TUBAL ABORTION; INTRA-PERITONEAL BLEEDING; LAPAROTOMY; RECOVERY.

Jahreiss reports in the *Münchener medicinische Wochenschrift*, 1892, No. 9, the case of a woman who had borne two children, who complained of profuse irregular bleeding persisting for two months, and occurring about every two weeks. Pain was also present, the patient stating that menstruation had been profuse since the death of her last child, when a midwife

had delivered an inherent placenta. An examination revealed the uterus nearly normal; the right fallopian tube showed dilatation. The left tube was normal. The patient was put at rest, given fluid extract of hydrastis, and an ice-bag placed upon the abdomen. This treatment failed to relieve the pain or check the hæmorrhage, and finally, a slight elevation of temperature, with a rise of pulse to 120 was observed. The symptoms were those of rupture of a tubal sac, although collapse, subnormal temperature, and profound anemia were absent. Upon opening the abdomen blood was found in the pelvis, and tubal abortion upon the right side was discovered. The patient recovered without complications. The right tube and ovary were removed, and the abdomen cleansed. On examining the tube clotted blood was found in it, but the ovum could not be distinguished. Rupture had occurred, although the orifice of the rupture was partly closed by the clot.—*Amer Jour. Med. Sci.*

HYDATIDIFORM-MOLE PREGNANCY.

Engel (*Centralbl. f. Gynäk.*, 1892, No. 1) has examined five cases of molar pregnancy which were observed in the course of 4,000 labor patients under his observation. These cases occurred in a woman aged 22, a 2-para; a second, aged 26, a 3-para; a third, aged 28, a 4-para, a fourth, aged 32, a 9-para; and a fifth, aged 46, who was the mother of no fewer than twenty children. The foetus could not be found in any of these cases. The most characteristic symptom was hæmorrhage, which began about the third month and lasted for weeks or even months, in the course of which period the uterus steadily increased in size. At first the blood was very serous and almost colorless. Later, old and recent clot came away. Another characteristic train of symptoms consisted in nausea, headaches, pallor, palpitations, and other phenomena, due to internal hæmorrhage. The uterine walls were always thin, the cervix participating in the morbid change. Hence, sharp instruments are out of the question. Ergot should be given, the vagina carefully plugged, and ultimately the cervix must be cautiously dilated with compressed sponges, the uterus being emptied by the hand.—*Brit. Med. Jour.*

FORCEPS AS AN AID TO VERSION.

Dr. W. Henry Harris, writes in the *Lancet*:—A case I was called to at a long distance, by two medical men in attendance, in Manitoba, may not be without interest. On arrival, I found the patient, aged twenty, in labor, then some twenty hours; primipara; seven months. On examination I found the right arm protruding (had been so some hours, the patient having been kept under chloroform,) the right shoulder firmly jammed, and constant powerful uterine contractions, so that the introduction of the hand for version seemed impossible. It occurred to me that if I could apply the forceps (Simpson's long) on the thorax at a point a little below its greatest diameter, gentle pressure would cause the blades to descend toward the pelvis, and so convert the presentation into an ordinary breech. The result was as I anticipated. In this case the foetus had been dead some hours and the labor premature. My reason for publishing this case in *The Lancet* is that I do not see "forceps as a means of version" quoted in the text-books, as well as to suggest that similar means might be applicable in cases where such unfortunate presentation has occurred.

GYNECOLOGY.

ILEO-COLOSTOMY.

Gross, of Nancy (*Sem. Méd.*, February 13, 1892) discusses the indications for ileo-colostomy in cases of ulceration and tumor of the cæcum. Maisonneuve, it is stated, was the first surgeon to aim at intestinal anastomosis in a case of internal strangulation, in which he stitched the small intestine to the cæcum in order to avoid the necessity of forming an artificial anus. This operation, which was performed in 1854, was followed soon after by a second, in which an attempt was made to relieve the patient by an artificial anus. Both these cases terminated fatally, death having been due in one case to peritonitis, in the other to suppurative perityphlitis. Although ileo-colostomy has not been frequently performed, much attention has been given to this operation, especially by German surgeons, and its methods have been improved by Salzer and Hochenegg. In the procedure advocated and successfully practised by the latter

surgeon, the two ends of diseased portion of gut, which has been completely separated from the rest of the intestinal tract, are fixed to the edges of the external wound in order to permit the discharge of mucous and purulent secretion. Ileocolostomy is held to be indicated under the following conditions: (1) In cases of tumor—particularly carcinoma—of the cæcum not amenable to direct operation. In cases in which the diseased portion of intestine is constricted, ileocolostomy will relieve the patient of the symptoms of obstruction. If such symptoms have not yet been manifested, the operation will have a prophylactic effect. Moreover, by removing the irritation caused by frequent contact of faecal matter the tumor will be less disturbed, the bad results of faecal retention will be avoided, and secondary pericæcal inflammation will be diminished if not altogether abolished. (2) Chronic or relapsing inflammatory affections of the cæcum, with ulceration and consecutive constriction and adhesion to surrounding structures; ulceration of tuberculous or other organs with pericæcal suppuration and stercoral fistulae. Free passage of faeces along the intestinal canal will necessarily result in suppression of the discharge of faecal fluid by the fistulae, and so render it possible for these to close and cicatrize. Moreover, as the seat of the disease is no longer infected by faecal matter, the inflammatory phenomena ought to diminish in intensity, if they do not wholly disappear. Ileocolostomy, however, as practised by Hochenegg, is a long, delicate and complicated operation, and it ought not, therefore, to be undertaken except under very favorable conditions, and when the general health of the patient is relatively satisfactory.—*Brit. Med. Jour.*

OVARIOTOMY IN A PATIENT IN HER EIGHTY-SECOND YEAR.

At a meeting of the British Gynaecological Society on March 24th, I recorded the particulars of an operation for ovarian tumor in a patient over 81 years of age, who recovered perfectly, of which some details may be interesting. The peritoneal cavity was filled with a clear yellowish-colored jelly-like fluid. The cyst, which was multilocular, extended up above the umbilicus. The main cyst contained thick colloid material, which had to be scooped out

with the hand. The peritoneal cavity was irrigated with warm water, and a drainage tube inserted. Convalescence was somewhat tedious, but satisfactory. The patient is now (April) quite well, and able to walk round her garden. Dr. Joyce, of Cranbrook, informs me. In Mr. Bland Sutton's table of twenty-two cases of ovariectomy in patients over 70, the oldest was only 80. This case, therefore, is the oldest yet recorded.—Arthur W. Edis, M. D. in *Brit. Med. Jour.*

PYOKTANIN INJECTIONS IN CARCINOMA OF UTERUS.

Boldt (*Merck's Bulletin* for January, 1892) says: Pyoktanin possesses great germ-destroying power, and is devoid of injurious effects on the animal economy if used with proper precautions. He quotes a case, Backmaier (*Wiener med. Presse*, 1891), where there had been hæmorrhage from the vagina for more than three months, uterus immovable, with parametric-infiltration involving anterior vaginal wall.

The injection, one-and-a-half to three syringefuls of a one-to-one hundred solution in different portions of the growth every second day for four months, resulted in disappearance of the anæmia; the ulcerated surface was even and covered with healthy granulations; the discharge was scanty and not bloody or ichorous; the infiltration had diminished, and the ulcer on vaginal wall was partially healed.

Four months subsequent to this improvement was steadily progressive.

Boldt also gave reports of four cases of his own. The women were from forty-two to fifty-three years of age and all had been bleeding irregularly from two to three months. They were emaciated, having intense pelvic pain—the anterior vaginal walls were more or less infiltrated; the vaginal portion of the cervix of all was nearly destroyed, and other recognized diagnostic evidences of malignancy was present. The treatment was through curetting; followed by a tampon of dry iodoform gauze. In one case the Paquelin cautery was required to stay hæmorrhage. After forty-eight hours gauze was removed, patient placed in Sims' position, parts dried and injection again used, care being taken to reach the deeper structures, with effort to keep the parts as thoroughly clean as possible, this treatment, with some mod-

ifications, is continued. The injection usually causes pain for half an hour.

Confident views are expressed that proper treatment by this drug will prolong life and alleviate suffering, and in some cases, perhaps, complete a cure, when the disease does not admit of radical surgical treatment. The hypodermic use of pyoktanin should not exceed grs. iiss. Hoge, in *Virg. Med. Monthly*, October, 1880, reports a case of failure, but Boldt alleges the remedy was used insufficiently, or that the solution might have been unstable.

PEDIATRICS.

OVARIAN CYSTS IN INFANTS.

Kissel (*Nouv. Arch. d'Obstét. et de Gynéc.*, October, 1891. Supplement, p. 458) found 30 cystic ovaries in 428 bodies of female children (362 from birth to 1 year old, the remainder from 1 to 13 years old.) In only one case of cystic ovary was the subject over 1 year, and that case was 13 months old. The younger the infant the higher up lay the cystic ovaries, the older infants bearing the tumors in the pelvis. The cysts most usually occupied the outer aspect of the ovary. The cysts were tense, sometimes larger than the ovary, and often had septa. The ovarian parenchyma was partly destroyed by the pressure of the cyst; sometimes there were traces of parenchyma on each side of the cyst. Why these cysts were so common in infants and rare in children Kissel could not explain. He carefully searched with the microscope, but could not once find any trace of cyst or cicatrix representing the site of a cyst. These cysts, must, it would seem, undergo a retrograde change, and, thanks to the youth of the patient, the parenchyma is probably reproduced.

A TOY BALLOON IN THE TRACHEA; REMOVAL.

Dr. W. C. Glasgow (*N. Y. Med. Jour.*, 1891, liv., 460.) gives the following history: The patient, a colored child, eight years old, was seen for the first time, April 22, 1891. It was stated that two hours previous to this time the child had swallowed a toy balloon, that she had had severe choking spells, but that in the interval her breathing was normal. When brought to the

clinic there seemed to be nothing the matter with her. Her breathing was perfectly quiet and normal; there was no cough; her voice was clear, and there seemed to be no interference with respiration. Suddenly, however, without any apparent cause, she began to struggle as if for air. She became quickly cyanotic, her cry was toneless, and there was frothing at the mouth. An examination of the chest showed a whistling râle over the left bronchus, with weakening of respiratory murmur. She was then chloroformed and a low tracheotomy done, but nothing could be detected even by the sound passed into the trachea. On the fifth day she had several coughing spells, with symptoms of strangulation, and during one of these attacks, a red substance was seen presenting at the tracheal wound. This was caught with a forceps, and although but gentle traction was used, the red rubber came away from its attachments, leaving the wooden tube in the trachea. This was forced upwards through the glottis and removed through the mouth. It was too large to pass through the tracheal opening. The next day surgical emphysema was seen over the whole anterior part of the chest. The left lung gave numerous mucous râles, with a distinct full respiratory murmur. The wooden part of the balloon measured an inch and three-sixteenths in length, and five-sixteenths of an inch in diameter.

THE TREATMENT OF SCARLATINA.

Since the publication of the treatment of the disease with chloral, by Dr. J. C. Wilson, in 1889, others have had some favorable experience with this drug. The theory of its action is a sedative to the nerve centres, and antiseptic to the blood and tissues with which it comes in contact in administration and elimination. It is given in doses just sufficient to keep the patient in a state of light somnolence. This will require about one-half to two grains for infants and children, and four to six grains for adults, repeated every three to four hours, according to effect. It is especially successful in preventing complications and sequelæ.

Curgenvén presented before the Epidemiological Society of England his method of treatment. The remedy used is oil of eucalyptus. He gives it internally in frequent doses (two to four hours) of a few

drops in emulsion or shaken up in water. He saturates the clothing and all bed-clothing, and sprinkles the floor, furniture and walls with it, until the entire air of the room is redolent with the odor. He sponges the body with it twice daily. It renders all other medication and disinfection, as well as isolation of the patient unnecessary.

His invariable results, after one year's experience, are the immediate arrest of the eruption, which does not extend further, the speedy relief of angina and subsidence of enlarged glands, the decline of temperature to nearly normal, and absence of albuminuria, due to the elimination of the oil by the kidneys. Thus the activity of the poison is very effectively checked within a few hours.

But he further states that if administered before eruption and active symptoms have set in, it will abort the disease, and that it will act as a complete prophylactic to those exposed to it.

Salicylic acid is rapidly acquiring a reputation in treatment, as well as prophylaxis, of this disease. In from two to five grains daily it is said to be effective in protecting the system against an attack.

Dr. Illingworth, in the *Edinburgh Medical Journal*, relates his experience in this disease with the biniodide of mercury, on the principle that it acts as a germicide. The dose used (for a child 7 years of age) is one-sixteenth of a grain thrice daily, rubbed up with sugar. However, he prefers giving every three or four hours a half drachm of the bichloride of mercury solution (Brit. Pharm.), giving, also, one and one-half to two grain doses of iodide of potassium at the same intervals. He claims the usual benefits, that it "modifies the course of the fever, reduces the temperature, checks or altogether prevents the inflammation of the skin, and prevents the dreaded sequelæ."—*Med. World*.

POSTICUS PARALYSIS IN INFANTS.

Dr. Robertson (*Lancet*, 1891, ii., 936.) read before the Northumberland and Durham Medical Society, a paper on the condition of childhood which he thus named. The symptoms included prolonged and difficult inspiration, sometimes even cyanosis, with drawing in of ribs during inspiration. Marked pharyngitis was pres-

ent. The symptoms were removed by repeated intubation and treatment of the pharyngeal affection. He regarded the symptoms as being due to bilateral impairment of the postici muscles.

HYGIENE.

EXAMINATIONS FOR ARSENIC IN THE LABORATORY OF THE HEALTH DEPARTMENT AT COPENHAGEN.

In a report on this subject, C. Gram states that in all 412 articles were subjected to a chemical analysis for arsenic. Of this number, 91, or 22 per cent., contained arsenic. Among 186 samples of wall-paper, 26 contained arsenic, 19, however, in minute quantity. Of 64 samples of wall-paper border, 30 contained arsenic, 14 only in traces. Among 78 samples of cloth and ribbon, 17 contained arsenic, all in considerable quantities. Of 17 samples of artificial flowers, 3 contained a very noticeable quantity. Of 50 kinds of candles examined, 15 contained arsenic in considerable quantity, all of which latter, however, came from the same manufactory.—*Tidskrift f. Sandhetsplei*, vol. ii, No. 4.

TRAILING DRESSES.

It is difficult to detect anything beautiful or becoming in skirts of such length as to gather up the maximum amount of dirt when its possessor takes her walks abroad. At the same time, the news that the Supreme Sanitary Board of Hungary has opened a "regular campaign" against dress trains on the ground that, by sweeping up the dust, they contribute to the spread of "tuberculosis and typhus fever and other maladies," is calculated to raise a smile. On æsthetic grounds these trailing garments are to be deprecated, but the merest zephyr probably causes more commotion of the germ-laden dust than the passage of a princess. This is playing at sanitation, and when one reflects upon the multitude of hygienic reforms more or less urgently called for in Continental countries, sumptuary edicts of this description remind one forcibly of the "straining at the gnat." Moreover, history teaches us that the ladies are not to be coerced in the matter of dress. Coaxing will sometimes—though rarely—bring about a partial reform, drastic measures, never. It is not a mere selfish dis-

regard for the health of others that underlies this obstinacy, because the ladies show the same lofty indifference when their own health is in question. The fact is, they feel intuitively that dress is one of the most potent factors in evolution, in respect of sexual selection. It is idle to warn them that small waists are as abhorrent to nature as a vacuum; they know by experience and tradition that small waists are appreciated, and small waists they must therefore have *per fas et nefas*.—*Med. Press*.

PROPHYLACTIC TREATMENT OF HEREDITARY TUBERCULOSIS.

Solles (*Rev. Mens. des Mal. de l'Enf.*, September, 1891.) believed that hereditary tuberculosis existed in a sporular form, the tubercular sporule being the progenitor of tuberculosis in the majority of cases. The proof of the existence of the tubercular sporule is that upon a section of a miliary granulation no bacilli are found, but if a rabbit is inoculated with this granulation, the animal will die from phthisis, and numerous bacilli may be found in its body. In most of the scrofulous lesions, which are very suggestive of tuberculosis, no bacilli are found. These facts seem to demonstrate the existence of a hereditary tuberculosis, which is not bacillar, but sporular. Phthisical and scrofulous subjects eliminate specific spores by their excretory organs. The author has demonstrated this to his own satisfaction by inducing tuberculosis in guinea pigs, which he had inoculated with the fæces, urine and semen of tubercular and phthisical subjects. These experiments enable one to formulate principles for the prophylactic treatment of hereditary tuberculosis. It would consist in the expulsion of the spores by increasing the functional activity of the excretory organs, the skin, kidneys, and intestine, thus preventing the development of the disease. It would further consist in securing the resolution of the sporule accumulations by the use of the iodide of potash, salt-water baths, and revulsives.

QUININE AS A PROPHYLACTIC AGAINST INFLUENZA.

Graesser first recommended quinine as a prophylactic in influenza in *Berl. Klin. Wochenschr.*, in Dec. 1889. Following his recommendation, Frauen used the drug

with good success. Each soldier of a battalion of infantry (about 450 men) received a daily dose of eight grains of quinine in whiskey; in the course of three or four days the influenza had entirely disappeared from amongst the soldiers, while it continued to spread amongst the civilian population of the town.

Finkler has likewise made favorable reports concerning this remedy, also claiming for it a direct curative action after the disease is fully established, which according to his experience, is not shared by antipyrine and salicylic acid.

Schelter reports his experience with the same method in a cavalry regiment. For over a week quite a number of cases of influenza had occurred in every one of the five troops of the regiment. He then commenced the daily administration of eight grains of quinine in one-half oz. of whiskey to each of the ninety-one men comprising the second troop. Only seven of these were taken sick subsequently; that is three men on the 2d, two on the 3d, one on the 5th and one on the 6th day. From this time on, the troop enjoyed an entire immunity from the disease, while in the remaining four troops the number of cases developing after the experiment was begun is given as 21, 19, 42 and 31, respectively. If the three men who were taken sick on the day after the first dose of quinine was given are left out, its prophylactic effect is even more striking.

THE ETIOLOGY OF FIBROMYOMA.

Prochownick, (*Deutsche med. Wochenschrift*, No. 7, February, 1892) observed several cases in which the patients were syphilitic and in which the antisymphilitic treatment had no effect whatever upon the myoma. Myomata are found in cases where there is either some specific irritation of the walls of the vessels, or where there is a tendency to the formation of tumors which grow as a result of irritation. The syphilitic virus may perhaps be considered a specific irritation in this sense, but the tendency of syphilis is to cause a contraction of the tissues, and not a proliferation. Observations would tend to make us look upon the theory of the formation of these growths as the result of a variety of irritative causes, as the more tenable and more satisfactory explanation.

MEDICAL CHEMISTRY.

DETERMINATION OF THE SPECIFIC GRAVITY OF POWDERS.

The *Chemischè Zeitung* thus describes the method of Smeeth. Vaseline is placed in a watch glass and heated to expel all air-bubbles. It is allowed to cool to 60° F. and the whole is then weighed in water. The vaseline is again slightly heated to fluidity and a weighed quantity of the powder to be tested is sprinkled over the surface. After cooling as before the whole is weighed and the usual calculations give the specific gravity desired.

NOTE ON PAYEN'S PROCESS FOR THE DETECTION OF FREE MINERAL ACIDS IN VINEGAR.

According to Payen's process, 100 cc. of the suspected sample are boiled for twenty or thirty minutes with 0.05 gm. of potato starch. If no mineral acids were present the starch will have been but little acted upon (dissolved), and will consequently show with the iodine test; but the presence of even 2 parts per thousand of sulphuric acid is said to be sufficient to convert all the starch into dextrin or glucose, and even then it will give no true coloration with iodine. This process is almost a standard one, and has scarcely ever been attacked; but F. Corril, a French analytical chemist, has stated recently that he cannot recommend it, as he still obtained the starch reaction with vinegar containing 5 parts of sulphuric acids or 5 parts of either hydrochloric or nitric acid per thousand. Hence vinegar dealers, unless their own experience agrees with Payen's for varying percentages of adulteration, should not rely too implicitly on this test.

NEWS AND MISCELLANY.

LEGAL RESTRICTIONS OF HYPNOTISM.

A bill to restrict the use of hypnotism has been introduced into the New York Legislature. It is entitled "An Act to Prohibit Public Exhibition of Hypnotic experiments, and to Prohibit Hypnotic Treatment by Anyone except duly Licensed Physicians." It contains the following clauses: (1) It shall be unlawful for any

person except duly licensed physicians in the course of lectures to medical students, or before scientific bodies, to give exhibitions of or perform hypnotic demonstrations in public. (2) It shall be unlawful for any person not a duly licensed physician to hypnotize another. (3) Any person violating either of the foregoing provisions of this act shall be guilty of a misdemeanor. It is expected that the bill will have the support of the medical profession throughout the State of New York. The English of the bill might with advantage be submitted to some authority on Parliamentary style for revision, but its meaning and intention are admirable, and we hope it may speedily become law. With the examples of Belgium and the United States before it, perhaps our own Legislature may at last be roused to take similar action.

EPILEPTIC COLONIES.

In the current number of the *Journal of Mental Science* Dr. C. Theodore Ewart discusses in an interesting manner the ever-present problem, What is to be done with epileptics? The question is discussed principally with reference to the working of epileptic colonies, in the establishment of which this country has taken so far scarcely any practical steps, and Dr. Ewart's paper is an important contribution towards the solution of the problem. After describing the various efforts which have been made in other countries to grapple with this subject, he summarizes the main principles which he thinks should be observed in the organization of such a colony. The first essential is land, to consist of at least 500 acres of farm and woodland, well adapted to agricultural and horticultural purposes, within easy access of a large city, which would naturally supply a market for the produce. Then there must be small buildings, arranged in separate divisions for the male and female patients, each of the divisions to make provision in separate cottages for the demented, the convalescents, the school children, the workers, and the private patients of the higher classes. Medical care of each patient must be provided for, and there must be educational provision for epileptic children, and workshops, farm buildings, dairy, etc., for the adults, as well as a special laboratory for the study of epilepsy by a skilled pa-

thologist. The two arguments advanced against the establishment of two types of asylums are that there would be a sameness of occupation, a want of hope, and an absence of object, calculated to drive a sane man into insanity in a short time. To this argument Dr. Ewart replies that in such a colony as is proposed there would be neither lack of objects nor absence of hope. The second argument touches the financial question, for it might be said that the drafting off of chronic cases would necessitate the introduction of a larger number of sane workmen and workwomen. To this Dr. Ewart's reply is that the welfare of the patient must be the first duty of a committee, and he protests against the idea that the chronic cases are incurable. Even if they are that is no reason why they should not be made useful, as such a course would give them an interest in life which, to say the least, would tend to ameliorate their condition. Besides, by separating the acute from the chronic, each class is placed in better circumstances for rapid recovery; the time of lodgment would thus be shorter, and the expense correspondingly lessened. This great problem is one which must be faced; it is obtruding itself more and more every day, and if by the means proposed we can in any way lessen the misery and brighten the lives of many of our fellow-men and women, while we protect the helplessness of childhood, and develop it into something better and more useful than under present conditions it has the chance of attaining, it is our duty, and it ought to be our pleasure, to make the attempt, even if it may entail at the commencement some sacrifices. But even from the economic point of view such a course will in the end bring its own reward.—*Lancet*.

THE ETIOLOGY, DIAGNOSIS AND TREATMENT OF THE PREVALENT EPI- DEMIC OF QUACKERY

Dr. Geo. M. Gould, in a recent paper under the above title writes: "I have been surprised to see how a few minutes' talk with such people (believers in homoeopathy) makes it plain to them what silly fools they have been, and how egregiously they have been duped. I have looked about for some scrap of literature I could hand to these

folks, to show them what roaring nonsense they unwittingly gave their assent to. Oliver Wendell Holmes's little skit is almost the only such thing. Convinced, however, that people need and will profit by simple instruction honestly, plainly, justly, put before them, I wish to have a little pamphlet prepared that, historically and actually, will show up the ridiculous pretensions of modern homoeopathic practice. I shall, therefore, postpone a bit of private pleasure I had planned, and offer a little prize of \$100.00 for the best essay on the subject. The essay should not contain over 15,000 words, and in simplicity and directness should be adapted to the commonest lay understanding. Papers should be sent me on or before January 1, 1893, type-written, without the name of the author, but accompanied by a sealed letter, giving the author's name with motto or *nom-de-plume*. The essay will be given to a competent committee, and when their decision is reached the sealed letters of the authors will be opened, and the prize sent the winner. The essay will then be cheaply but well printed in large quantities, and supplied physicians at the cost of printing."

THE VIENNA MEDICAL SOCIETY.

At a recent meeting of the Imperial Royal Medical Society of Vienna, Professor Billroth announced that 9,000 florins had been subscribed for the erection of a building to be used as the permanent home of the organization. Of this amount the Emperor gave 5,000, and a lady who wished to remain anonymous gave 4,000. The individual members of the society then subscribed a sufficient amount to secure the erection of the building.

THE PHYSICIAN.

The following is a translation of an epigram written by Cordus in the sixteenth century:

The Physician like an angel seems
When he in the sick room brightly beams,
And like unto a god is he
When he's removed the malady.
But in a different light we view
The doctor when his bill is due:
Our alter'd eyes we at him level
As though he were the very devil.

—Dr. Carl.